HWCNNews

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## Common HMO Examination Findings

The Department has authority to conduct examinations of HMOs under Texas Insurance Code (TIC) §843.156 and Texas Administrative Code (TAC) §11.303. During the past few years, TDI examiners have discovered that several errors and omissions are common to many HMOs during examinations. The purpose of this article is to share a few of the common errors and omissions with HMOs in an effort to assist HMOs in avoiding them. Prevention will not only result in day-to-day compliance with applicable statutes and TDI rules, but may also result in fewer or no findings during an examination.

With this goal in mind, the Department asks that HMOs watch for the common errors and omissions listed below to avoid findings during examinations. These common errors and omissions may also be found during complaint investigations. Many of the errors and omissions may result from lack of documentation in files or may result because policies and procedures are incomplete. However, many may also result from the HMO's failure to routinely monitor its operations for compliance with applicable statutes and TDI rules.

**Common Errors and Omissions:** Please note that the following errors and omissions are not listed in any specific order.

1. **Complaints:** Currently, TDI examiners request randomly selected complaint files from the logs provided by the HMO. The most common errors and omissions are as follows:
   - The files do not include sufficient documentation to prove compliance with applicable requirements. For example, the files do not contain a copy of the complaint acknowledgement letter or the complaint resolution letter. Examiners review these letters to determine whether the required letters were sent and whether all required information is included in the letters. If the letters are not in the file, TDI examiners can only conclude that the letters were not sent to the complainants and the examination report will reflect non-compliance and low percentages of compliance. To avoid non-compliance findings, HMOs must ensure that the files contain any and all documentation that proves compliance.
   - Complaint Acknowledgement Letter: This letter is typically vague and incomplete. A complaint acknowledgement letter must include all requirements related to complaints and appeals. Chapter 843 Subchapter G of the TIC (relating to Dispute Resolution) contains the requirements for both the initial complaint process and the appeal process. TIC §843.251(a) provides that the complaint system must include a process for the notice and appeal of a complaint. The HMO's "complaint system," therefore includes the appeal of the complaint. Accordingly, all appeal procedures and timeframes and must be communicated to the complainant in the acknowledgement letter. To avoid non-compliance findings, TDI recommends that HMOs create template attachments that include all requirements and which can easily be attached to the letter.
   - Complaint Categories: Per 28 TAC §11.205 (a)(4), each complaint must be categorized as one or more of the types listed in TDI rule (e.g. including but not limited to, quality of care or services, accessibility and availability of services). To determine whether the HMO is compliant with this requirement, examiners look at the HMO's complaint and appeal logs. Examiners regularly find that the logs either do not contain any of the required categories or contain some but not all of the required categories. Examiners also find that the HMO's policies and procedures related to the complaint logs and categories also do not include any of the required categories or

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include some but not all of the required categories. To avoid non-compliance findings, HMOs should immediately review their current logs and make corrections.

**2 Identification (ID) Cards:**

- Per 28 TAC §21.2820, ID cards must include the letters "TDI" or "DOI" prominently displayed on the front of the ID card. Examiners frequently find that HMOs do not include "TDI" or "DOI" on ID cards issued to enrollees. This requirement is equally applicable to CHIP ID cards. Several HMOs have disputed this requirement in relation to CHIP plans because the plan is partially administered by the Texas Health and Human Services Commission (HHSC). However, CHIP plans must comply with most TDI requirements. In addition, HHSC has agreed with TDI that CHIP ID cards must include the letters "TDI" or "DOI" on ID cards.

**3 Utilization Review:**

- The files do not include sufficient documentation to prove compliance with applicable requirements. As in the case with complaints, utilization files typically do not include copies of letters, which evidence that letters were sent. One common omission in the file documentation, proves that the provider was offered a reasonable opportunity to discuss the adverse determination (commonly referred to as "peer-to-peer") prior to sending the adverse determination (see TIC §4201.206). Even if HMOs maintain that the peer-to-peer is provided, examiners have no choice but to conclude that the peer-to-peer was not offered if the file does not contain documented proof (e.g. including but not limited to, system notes, letters). HMOs cannot prove compliance without documentation. To avoid non-compliance findings, HMOs must review their files to ensure that documentation which proves compliance is included in the files.
- Another common error is the "intermingling" of complaints and adverse determinations, not only in logs, but in the application of statutes and rules. For example, HMOs may categorize an adverse determination as a complaint and follow the process for resolving a complaint. The result being that none or most of the requirements related to adverse determinations have been followed. When an adverse determination is handled as a complaint, enrollees and providers are not informed about their right to independent review, which is not available for complaints. The HMO is, therefore, misleading enrollees and providers by not informing them about their rights or vice versa; informing an enrollee or provider of a right to independent review where inapplicable. To avoid non-compliance findings, HMOs should perform routine self audits of its processes and files. In addition, if the problem originates from "intermingling" complaints and adverse determinations in one log, HMOs may need to keep two logs, one for complaints and one for adverse determinations.

**4 Form Filings, Including Delegation Agreements:**

- All examinations during the past few years have resulted in the finding that forms were not filed as required in 28 TAC §11.301. HMOs may fail to file HMO forms (e.g. EOCs, provider contracts) due to inadvertent oversights.

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## Common HMO Examination Findings

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> However, it is difficult to come to the same conclusion in relation to delegation agreements. Based on this recurring finding for most if not all HMOs, examiners can only surmise that HMOs are not sufficiently acquainted with the requirements related to delegation agreements. The Department encourages HMOs to become better acquainted with these requirements. 28 TAC Chapter 11 Subchapter AA (§§11.2601-11.2612) provides clear guidance about delegated entities, delegation agreements and the filing of executed delegation agreements (§11.2611).

Although not all errors and omissions have been mentioned in this article, TDI examiners believe that most errors and omissions may be easily avoided by routine self audits and by continually educating its staff. In addition, TDI offers numerous checklists on its website that can help HMOs with self audits and education of staff. The checklists and other valuable information can be found in TDI's website at www.tdi.state.tx.us. Information specific to HMOs, including links to checklists, related to complaints, utilization review, and delegation, can be located at http://www.tdi.state.tx.us/wc/wcnet/index.html.

In conclusion, TDI examiners fully recognize the hard work performed by HMOs in preparation for an exam. It is understandable, in most cases, that failure to provide all documentation is not intentional and that many errors and omissions can be explained or corrected. TDI examiners appreciate and acknowledge these efforts and want to help HMOs in any way possible to allow HMOs to be fully compliant.

## HMO "Matrix" EOC Filings

An "evidence of coverage" (EOC) is a document that describes the benefits and services to which an HMO enrollee is entitled under a health benefit plan. Each HMO EOC must be filed with and approved by the Commissioner of Insurance prior to being offered and issued by the HMO.

When it is filed with the Commissioner, an EOC filing must be complete and must include:

- a cover letter;
- the HMO Certification and Transmittal Form;
- any necessary supporting documentation, e.g., rates, other form(s) for use with the EOC filing;
- an explanation of variability; and
- a unique form number for each form.

Any variable EOC language must be [bracketed] and must include the range of variable information or amounts (e.g. monetary, time frames).

A change in the HMO rules that went into effect November 15, 2006, permits HMOs to file with the Commissioner a special type of EOC called a "matrix" EOC. A matrix EOC may include changeable language and variable provisions. Also, different versions of the matrix EOC may include various combinations of previously approved provisions when issued to particular groups by the HMO.

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## HMO "Matrix" EOC Filings

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When an HMO files a matrix EOC, the HMO:

- must include a cover letter explaining that the filing is a matrix form;
- must identify each provision with a unique form number that is sufficient to distinguish it as a matrix filing; and
- may use the same provision filed under one form number for all HMO products, provided the language is applicable to each HMO product, but any changes in the language to comply with the requirements for each HMO product require a unique form number.

A filing fee is applicable, for a matrix EOC, the filing fee is $100 per form up to a maximum of $500 per matrix filing. The HMO is billed by the Department after the EOC is reviewed and either approved or disapproved by the Commissioner.

## Utilization Review Agents Complaints Reporting Requirements

A utilization review agent (URA), is an organization registered and/or certified by the Texas Department of Insurance (Department), to review medical necessity requests. Since URAs are registered and/or certified by the Department, they must adhere to requirements in accordance with the TIC and TAC. The Department requires URAs to establish and maintain a complaints process, by which health care providers, enrollees, injured employees, and their representatives may voice concerns with a URA's decision process.

In addition to this requirement, the Department mandates certain reporting criteria. By March 1st of each year (annually), each individually-certified URA must submit to the Department, a summary report of all complaints from the prior year received January 1st to December 31st..

**Health Maintenance Organizations (HMOs)**

For URA complaints related to HMO coverage, the annual report must include the following data: (see 28 TAC §19.1716(b)(1-6))

- total number of written notices of adverse determinations;
- a listing of any appeals made, subsequent to the adverse determination;
- classification of appellant (e.g. health care provider, enrollee or patient);
- subject matter of adverse determination;
- disposition of the appeal of adverse determination (either in favor of the appellant, or in favor of the original utilization review determination) at each level of the notification and appeal process; and
- subject matter of the complaint.

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# Utilization Review Agents Complaints Reporting Requirements

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**Workers' Compensation** {(Certified Workers' Compensation Network (WCNet) and Non-Network Workers' Compensation (WC)}

For URA complaints related to workers compensation coverage, the annual report must include the following data: (see 28 TAC §19.2016(b)-(c))

- administration (e.g. too many calls or written requests for information from the provider (s));
- qualifications of utilization review agent's personnel;
- complaint process (e.g., no "Peer-to-Peer", no notice of adverse determination, no notice of clinical basis for adverse determination, written procedures for appeal to TDI-DWC not provided);
- total number of written notices of adverse determinations;
- a listing of adverse determinations for preauthorization, by the medical condition and treatment using primary ICD-9 (physical diagnosis) code or DSM-IV (mental health diagnosis) code, and CPT (procedure) code or other relevant procedure code if a CPT designation is not available, or any other nationally recognized numerically codified diagnosis or procedure; and
- classification of party requesting review (e.g., health care provider, injured employee, their representative).

If the Department determines that a URA is non-compliant with any of these provisions, the Department may initiate administrative action.

# Texas Licensed and Specialty Reviewers for WCNet and WC Cases

The HWCN division stresses the importance of notifying us in the event that an IRO does not have appropriate staff available to perform IRO reviews. As it relates to workers' compensation recent legislation requires IROs and URAs to utilize Texas licensed doctors and specialty appropriate doctors ( See 28 TAC §133.308 (c) and (d)). Due to time constraints an IRO should notify the Department immediately when it is unable to perform an IRO review.

While an IRO must have appropriate specialists and Texas licensed reviewers, the following is a list of doctors, physicians, and specialist (reviewers) that we have noted are utilized most in WCNet and WC IRO cases. This list is not inclusive of all required reviewers, and is shared only for informational purposes. This information was queried from the most recent fiscal year.

1. Orthopedic Surgery
2. Chiropractor
3. Anesthesiology/Pain Management
4. Neurological Surgery
5. Physical Medicine/Rehabilitation
6. Psychology
7. Psychiatry

## Time is Money; How to Avoid Paying Extra Fingerprinting Fees

Since January 1, 2007, the officers and directors of a regulated entity must provide fingerprints to the Department in conjunction with an application for registration, certification and/or certificate of authority. The fingerprinting fee is $34.25 and pays for criminal history background checks performed by both the Texas Department of Public Safety (DPS) and the Federal Bureau of Investigation.

This requirement applies, but is not limited to:

- Workers' Compensation Network original and service area expansion applications
- Utilization Review Agent original, renewal, and update applications
- Independent Review Organization original, renewal, and update applications

If you are submitting an original application or your organization has had new officers or directors since its last application, a fingerprint card and a check made to the order of DPS must accompany your application. You must submit a separate check per fingerprint card. Fingerprints can also be submitted electronically by utilizing the services of L-1 Solutions, the selected vendor to implement Fingerprint Applicant Services of Texas (FAST). If L-1 Solutions is used, the receipt for FAST must be submitted with the application.

DPS will no longer process criminal history information for TDI when a white fingerprint card that a law enforcement agency uses for arrestees is submitted. Applicants should request fingerprint cards from TDI. These blue and white (Form No.FD-258) fingerprint cards contain TDI's ORI name and number. If a fingerprint card is rejected by DPS twice due to various reasons, such as but not limited to: smeared prints, light images or altered cards. The applicant will be required to submit a new card as well as an additional fee of $34.25.

## 81st Legislature Regular Session

The Texas Legislature will convene for the 81st Regular Session at noon on January 13, 2009. Pre-filing of legislation began November 10, 2008. The 81st Regular Session ends on June 1, 2009. After the Legislature adjourns on June 1, there are two important dates to remember: (1) June 21, 2009, is the last day the Governor can sign or veto bills passed during the regular legislative session; and (2) August 31, 2009, bills without specific effective dates become law. For more information on the 81st Legislature Regular Session please visit Texas Legislature Online at www.capitol.state.tx.us.

## Meet TDI Staff Member Rebecca Farless

Rebecca began working for the Texas Workers' Compensation Commission in 2004 in Medical Dispute Resolution making Independent Review Organization (IRO) assignments for Workers' Compensation Non-Network (WC) preauthorization disputes. In January 2007, Rebecca transitioned to TDI's HWCN Division, where she began making IRO assignments for WC, Certified Workers' Compensation Networks (WCNet), and Health cases.

As an Insurance Specialist some of her other responsibilities include responding to:

- Utilization Review Agent (URA) inquiries;
- IRO inquiries;
- WC and WCNet inquiries;
- Health Maintenance Organizations (HMO) inquires;
- reviewing URA/IRO applications;
- reviewing HMO Utilization Review files for compliance with state rules and statues;
- public education; and
- writing articles for the HWCN Newsletter.

In July of 2008, Rebecca was awarded employee of the month for the HWCN Division for her commitment to division training and education initiative. She reviewed, researched, tested, and provided feedback for new training manuals and job aides.

## We Want to Hear from YOU!

We hope you have enjoyed this and other issues of the HWCN Newsletter. Our next issue is scheduled for release in April. Please feel free to let us know if there is a topic you wish to have us address. You can email us your suggestion at HWCN@tdi.state.tx.us or give us a call at 1-866-554-4926. We also welcome you to participate in our Network Applicant and/or Provider Office Manager Conference Calls as scheduled below.

### 2009 CALENDAR OF EVENTS

**Network Applicant Conference**
**Call 1-888-387-8235 - passcode 6622666**
Thursday, January 8, 2:00-3:00 p.m. CST
Thursday, March 12, 2:00-3:00 p.m. CST

**Provider/Office Manager Conference**
**Call 1-888-387-8235 - passcode 6622666**
Tuesday, January 13, 2:00-3:00 p.m. CST
Tuesday, March 10, 2:00-3:00 p.m. CST

## HAPPY NEW YEAR!