SUBCHAPTER A. General Provisions and Definitions
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1. INTRODUCTION. The Texas Department of Insurance proposes new §§10.1 - 10.2, 10.20 - 10.27, 10.40 - 10.42, 10.60 - 10.63, 10.80 - 10.86, 10.100 - 10.104, and 10.120 - 10.122 (collectively referred to as Chapter 10) concerning workers' compensation health care networks. These new sections are necessary to implement Article 4 of House Bill (HB) 7, enacted by the 79th Legislature, Regular Session, effective September 1, 2005. Article 4 of HB 7 is cited as the Workers' Compensation Health Care Network Act and codified at Texas Insurance Code Chapter 1305 (the Act).

Under HB 7, the 79th Legislature directed the commissioner of insurance to adopt rules as necessary to implement the Act not later than December 1, 2005. Further, the Legislature directed the department to accept applications from a network seeking

certification under the Act beginning January 1, 2006. These proposed new sections will be applicable on January 1, 2006.

The Act authorizes insurance companies; certified self-insurers for workers' compensation insurance; certified self-insured groups under Labor Code Chapter 407A; and governmental entities that self-insure, either individually or collectively, (all the preceding collectively defined in these sections as “insurance carriers”) to establish or contract with certified networks for the delivery of health care services to injured employees of employers who elect to receive workers’ compensation coverage through networks.

Under the Act, if the employer elects workers’ compensation network coverage, the employer’s injured employees who receive workers’ compensation coverage and who live within the network’s service area must obtain medical treatment for a compensable injury within the network, except under certain specified circumstances. Injured employees who live within the service area of a network and who are being treated by a non-network provider for an injury that occurred before the employer’s insurance carrier established or contracted with a network, must select a network treating doctor, or under specified circumstances, the employee’s health maintenance organization (HMO) primary care physician or provider who agrees to serve as a network treating doctor, upon notification by the carrier that health care services are being provided through a network. Further, the Act outlines standards for the certification, administration, evaluation, and enforcement of the delivery of health care

services to injured employees by networks contracting with or established by workers' compensation insurance carriers.

Proposed new Chapter 10 establishes standards and requirements applicable to networks, insurance carriers, other persons, and third parties operating under the Act. The proposed standards and requirements relate to network certification; contracting; notice; plain language; selection of a treating doctor; dispute resolution related to whether an employee lives within the network service area; network operations; utilization review; retrospective review; and complaints. The proposal should be read in conjunction with the Act; Insurance Code Chapter 5 Subchapter D and Labor Code Title 5 and related rules; and other statutes and rules, as applicable.

In this proposal, the department was guided by the 79th Legislature's expressed intent and direction that the workers' compensation health care network system resemble group health insurance plans as closely as possible. For this reason, many of the proposed sections mirror the provisions for HMOs and group health insurance plans.

This proposal reflects the department's efforts to address concerns necessary to implement the Act at this time. The department recognizes that additional rulemaking may be necessary in the future to address ongoing concerns that have been or will be raised regarding implementation of the Act as networks become certified and operational.

Proposed Subchapter A contains general provisions and definitions regarding this chapter. Proposed §10.1 explains the purpose and scope of this chapter. Proposed §10.2 defines certain terms used in this chapter.

Proposed Subchapter B describes the process for the certification of workers' compensation health care networks. Proposed §10.20 provides that certification under Insurance Code Chapter 1305 and the other provisions of proposed Chapter 10, except under certain circumstances, is a requirement for operating a workers' compensation health care network. Proposed §10.21 sets forth the requirement that a verified certificate application must be filed on prescribed forms accompanied by a non-refundable application fee and describes where to obtain the prescribed forms for the certificate application from the department. Proposed §10.22 lists the requirements for the contents of the certificate application. Proposed §10.23 states that the commissioner will approve or disapprove an application for certification of a network in accordance with Insurance Code §1305.054. Proposed §10.24 lists the financial information that certified networks must provide to the department and carriers with which the network contracts. Proposed §10.25 lists the filing requirements for networks after issuance of the network's certification and states that the network shall file with the department a written request for approval before making such changes. Proposed §10.26 sets forth the requirements for modification to a network's service area and identifies the associated information a network must provide to the department for prior approval when it modifies a service area. Proposed §10.27 provides the requirements

for modification to a network's network configuration, including filing an application with the department for prior approval for network configuration modifications.

Proposed Subchapter C contains information regarding the contracting requirements for workers' compensation health care networks. Proposed §10.40 states the requirements for management contracts for networks. Proposed §10.41 states the requirements for contracts between networks and insurance carriers. Proposed §10.42 states the requirements for contracts between networks and providers.

Proposed Subchapter D details various network requirements. Proposed §10.60 specifies notice of network requirements and employee information, which include both the notice of network requirements and employee information and the employee acknowledgment form. This section also sets forth the notice and acknowledgment form requirements, such as standards for language and readability. Proposed §10.61 contains requirements for employees who live within the network's service area and specific information related to employee access and insurance carrier liability for health care. Proposed §10.62 outlines the dispute resolution process for an employee who asserts that he or she does not currently live in the network's service area. Proposed §10.63 states the plain language and other requirements for the notice of network requirements and employee information and acknowledgment form.

Proposed Subchapter E lists network responsibilities related to network operations. Proposed §10.80 outlines the accessibility and availability requirements for networks and network providers. Proposed §10.81 describes the quality improvement program for monitoring and evaluating the quality and appropriateness of health care

and network services. Proposed §10.82 outlines the credentialing process for network doctors and health care practitioners. Proposed §10.83 contains information about the treatment guidelines, return-to-work guidelines, and individual treatment protocols for network care. Proposed §10.84 states compliance requirements for treating doctors. Proposed §10.85 provides for an employee's selection and change of a treating doctor. Proposed §10.86 specifies the criteria for a network's establishment and maintenance of telephone access logs.

Proposed Subchapter F sets forth the utilization review and retrospective review requirements for networks, including requirements that represent areas of conflict between the Act and Insurance Code Article 21.58A. Proposed §10.100 states that Insurance Code Article 21.58A applies to utilization review conducted in relation to claims in a workers' compensation network and, in the event of a conflict, the requirements of the Act apply. Proposed §10.101 requires that screening criteria used for utilization review and retrospective review related to network health care must be consistent with the network's treatment guidelines, return-to-work guidelines and individual treatment protocols and must include a process requiring a treating doctor or specialist to request approval from the network for deviation from the treatment guidelines, screening criteria and individual treatment protocols, as applicable. Proposed §10.102 establishes notice requirements for persons performing utilization review or retrospective review for an injured employee receiving health care services in the network. Proposed §10.103 sets forth standards for reconsideration of adverse determinations, including requirements for maintaining and making available a written

description of the reconsideration procedures involved in making an adverse determination. This section also requires that the reconsideration procedures be reasonable and contain certain provisions. Proposed §10.104 specifies the various procedural requirements for an injured employee, person(s) acting on behalf of an injured employee, or an injured employee's requesting provider seeking independent review of adverse determinations. Among other requirements, the section provides that the department shall assign the review request to an independent review organization, and the insurance carrier shall pay for the independent review provided under this subchapter.

Proposed Subchapter G describes requirements relating to complaints. Proposed §10.120 requires each network to implement and maintain a complaint system that provides reasonable procedures for resolving oral or written complaints. Proposed §10.121 establishes requirements for complaints and deadlines for responses and resolutions. Proposed §10.122 states that persons who are dissatisfied with the resolution of complaints by the network may file a complaint with the department, and states how persons may obtain complaint forms.

2. FISCAL NOTE. Margaret Lazaretti, Deputy Commissioner, HMO Division, has determined that for each year of the first five years the proposed sections will be in effect, there will be an increase in revenue to state government due to the certification application fees collected by the department in the approximate amount of $175,000 the first year, $100,000 the second year, and $50,000 in each year from 2008 through 2010

as a result of the enforcement and administration of the proposed sections. These anticipated amounts are based on an estimated number of certification application filings with the department of 35 applications in 2006, 20 applications in 2007, and 10 applications in each year from 2008 through 2010, and on a proposed nonrefundable $5000 fee for each certification application filed with the department. There will be no fiscal impact to local governments as a result of the enforcement or administration of the rule. There will be no measurable effect on local employment or the local economy as a result of the proposal.

3. PUBLIC BENEFIT/COST NOTE. Ms. Lazaretti has determined that for each year of the first five years the proposed sections are in effect, the public benefits anticipated as a result of the proposed sections will be a workers' compensation health care network system that provides injured employees cost effective, prompt, and high quality medical care; facilitates injured employees' return to work as soon as it is considered safe and appropriate; and provides a fair and accessible complaint resolution process. The proposed sections reflect the 79th Legislature's expressed intent and direction that the workers' compensation health care network system resemble group health insurance plans as closely as possible. Many of the proposed sections implement this legislative direction and closely resemble the statutory and regulatory provisions for HMOs and group health insurance plans.

Proposed §10.42(b)(5) requires provider contracts and subcontracts to include a requirement that the network provide notice to the provider at least 90 days before the

effective date of a termination of network provider status. Insurance Code §1305.152(c)(4) requires provider contracts and subcontracts to include a clause regarding appeal by the provider of termination of provider status and applicable written notification to employees regarding a termination. Since the statute already requires that a network have a system for notifying affected employees of provider termination, the only cost to a network as a result of proposed §10.42(b)(5) would be the actual cost of creating and transmitting the notice to employees. The department estimates the cost of creating the notice at between one and four cents per notice, and the cost of handling and transmission to be approximately seventy-five cents.

Proposed §10.60(h) requires that an employer establish a standardized process for delivering the notice of network requirements and acknowledgement form, so the only costs stemming from proposed §10.60(h) are those of establishing and implementing a standardized process and documenting the delivery. Insurance Code §1305.005(e) requires an employer to provide to the employee the notice of network requirements and acknowledgment form. The proposed section allows the employer the flexibility to design and implement a system of its choosing, so long as it is standardized and produces documentation. Consequently, as a result of this flexibility, costs will vary depending on the system the employer chooses. The department estimates the cost range of establishing the system at between $25 and $500 per employer. The cost of documenting notice of delivery and maintaining that documentation will vary depending on the number of employees to whom an employer must provide notice.

Proposed §10.62 requires the insurance carriers to resolve disputes, relating to where an employee lives, within seven days. This requirement could result in additional costs to insurance carriers. The amount of those additional costs will depend on how many disputes of this nature the insurance carrier receives and must resolve, as well as the type and number of personnel the insurance carrier employs or retains to resolve disputes. According to 2004 data from the U. S. Bureau of Labor Statistics Occupational Employee Statistical Survey, as reported by the Texas Workforce Commission, the mean hourly wage rate for claim adjusters, examiners, and investigators employed by insurance carriers and related activities is $24.21.

Proposed §10.24(b) requires a network to provide its financial statements to the department and to each insurance carrier with which the network contracts. Insurance Code §1305.201(a) - (b) requires each network to file the network’s financial statements with the department but does not require each network to provide those financial statements to each insurance carrier with which the network contracts. The only additional cost as a result of proposed §10.24(b) would be the cost required to copy and transmit the financial statements. The department estimates the cost of copying to be between one and four cents per page. The total cost of copying, as well as that of transmission, will vary according to the size of the network's financial statement. To reduce costs, a network may transmit the financial statement to a carrier electronically by mutual agreement.

Any additional economic costs currently exist under existing rules or result from the enactment of Insurance Code Chapter 1305 and are not a result of the adoption,

enforcement, or administration of the proposed sections. There will be no difference in the cost of compliance between a large and small business as a result of the proposed sections. Based upon the cost of labor per hour, there is no disproportionate economic impact on small or micro businesses. Even if the proposed sections would have an adverse effect on small or micro businesses, it is neither legal nor feasible to waive the provisions of the proposed sections for small or micro businesses because the Insurance Code requires equal application of these provisions to all affected individuals.

4. REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on October 3, 2005, to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comments must be simultaneously submitted to Margaret Lazaretti, Deputy Commissioner, HMO Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

The department will consider the adoption of the proposed Chapter 10 in a public hearing under Docket No. 2622 scheduled for Thursday, October 6, 2005, at 9:30 a.m. in E1 Level, Room E1.004 of the State Capitol Building, Capitol Extension Auditorium, 1400 N. Congress, Austin, Texas. The public hearing may be continued through October 7, 2005, if necessary. **FOR SECURITY PURPOSES VISITORS TO THE CAPITOL EXTENSION AUDITORIUM MUST ENTER THROUGH THE CAPITOL. VISITORS WITHOUT A STATE AGENCY OR DEPARTMENT OF PUBLIC SAFETY**

ISSUED IDENTIFICATION MAY REQUIRE ADDITIONAL TIME TO GO THROUGH THE SECURITY PROCESS.

5. STATUTORY AUTHORITY. The new sections are proposed under Insurance Code Chapter 1305, Articles 5.55C and 5.62, 21.58A and §§31.001 and 36.001, and Labor Code Chapter 405. Insurance Code §1305.007 authorizes the Commissioner of Insurance to adopt rules as necessary to implement Insurance Code Chapter 1305. In addition, §1305.005(i) authorizes the Commissioner of Insurance to adopt rules as necessary to implement §1305.005. Section 1305.052 requires a certificate application to be accompanied by a nonrefundable fee set by commissioner rule. Section 1305.401 provides that the Commissioner of Insurance may adopt rules as necessary to implement §1305.401. Section 1305.403 requires the Commissioner of Insurance to adopt rules designating the classification of network complaints under §1305.403. Insurance Code Article 5.55C(d) requires that a deductible policy provide that the company or association will make all payments for benefits that are payable from the deductible amount and that reimbursement by the policyholder shall be made periodically, rather than at the time claim costs are incurred. Article 5.55C(e) provides that the company or association shall service all claims that arise during the policy period, including those claims payable, in whole or in part, from the deductible amount. Insurance Code Article 5.62 empowers the Commissioner of Insurance to make and enforce all such reasonable rules and regulations not inconsistent with the provisions of Insurance Code Chapter 5 Subchapter D, relating to workers' compensation insurance,

as are necessary to carry out its provisions. Insurance Code Article 21.58A, §13 authorizes the commissioner to adopt rules and regulations to implement the provisions of Article 21.58A. Insurance Code §31.001 clarifies that in the Insurance Code, a reference to "commissioner" means the Commissioner of Insurance. Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state. Labor Code §405.004(g) requires the Commissioner of Insurance to adopt rules as necessary to establish data reporting requirements to support the research duties under Chapter 405.

6. CROSS REFERENCE TO STATUTE. The following statutes are affected by this proposal:

Rules	Statute
§§10.1 – 10.2, 10.20 - 10.27,	Insurance Code Chapter 1305 and
10.40 - 10.42, 10.60 - 10.63,	Articles 5.55C, 5.65 and 2158A
10.80 - 10.86, 10.100 - 10.104,	Labor Code Chapter 405
10.120 - 10.122	

Insurance Code Chapter 1305 and Articles 5.55C, 5.65 and 2158A, and Labor Code Chapter 405

7. TEXT.

Subchapter A. General Provisions and Definitions

§10.1. Purpose and Scope.

(a) This chapter implements provisions of the Workers' Compensation Health Care Network Act, Insurance Code Chapter 1305, and provides standards for the certification, administration, evaluation, and enforcement of the delivery of health care services to injured employees by networks contracting with or established by:

(1) workers' compensation insurance carriers;

(2) employers certified to self-insure under Labor Code Chapter 407;

(3) groups of employers certified to self-insure under Labor Code Chapter 407A; and

(4) governmental entities that self-insure, either individually or collectively, under Labor Code Chapters 501 - 505, except as described in subsection (c) of this section.

(b) This chapter applies to:

(1) each person who performs a function or service of a workers' compensation health care network as defined by §10.2 of this subchapter (relating to Definitions), including a person who performs a function or service delegated by or through a workers' compensation health care network; and

(2) an insurance carrier as defined by Labor Code §401.011 that establishes or contracts with a workers' compensation health care network.

(c) This chapter does not apply to health care services provided to injured employees of a self-insured political subdivision or injured employees of the members of a pool established under Government Code Chapter 791 if the political subdivision or pool elects to provide health care services to its injured employees in the manner

authorized under Labor Code §504.053(b)(2), relating to self-insured subdivisions or pools directly contracting with health care providers, or by contracting through a health benefits pool established under Local Government Code Chapter 172.

(d) This chapter does not authorize a workers' compensation insurance policyholder who purchases a deductible plan under Insurance Code Article 5.55C to contract directly with a workers' compensation health care network for the provision of health care services to injured employees.

(e) This chapter becomes applicable January 1, 2006.

§10.2. Definitions.

(a) The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise.

(1) Adverse determination--A determination, made through utilization review or retrospective review, that the health care services furnished or proposed to be furnished to an employee are not medically necessary or appropriate.

(2) Affiliate--A person that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, the person specified.

(3) Capitation--A method of compensation for arranging for or providing health care services to employees for a specified period that is based on a predetermined payment for each employee for the specified period, without regard to the quantity of services provided for the compensable injury.

(4) Complainant--A person who files a complaint under this chapter. The term includes:

(A) an employee;

(B) an employer;

(C) a health care provider; and

(D) another person designated to act on behalf of an employee.

(5) Complaint--Any dissatisfaction expressed orally or in writing by a complainant to a network regarding any aspect of the network's operation. The term includes dissatisfaction relating to medical fee disputes and the network's administration and the manner in which a service is provided. The term does not include:

(A) a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the complainant; or

(B) an oral or written expression of dissatisfaction or disagreement with an adverse determination.

(6) Credentialing--The review, under nationally recognized standards to the extent that those standards do not conflict with other laws of this state, of qualifications and other relevant information relating to a health care provider who seeks a contract with a network.

(7) Emergency--Either a medical or mental health emergency.

(8) Employee--Has the meaning assigned by Labor Code §401.012.

(9) Fee dispute--A dispute over the amount of payment due for health care services determined to be medically necessary and appropriate for treatment of a compensable injury.

(10) HMO--An health maintenance organization licensed and regulated under Insurance Code Chapter 843.

(11) Independent review--A system for final administrative review by an independent review organization of the medical necessity and appropriateness of health care services being provided, proposed to be provided, or that have been provided to an employee.

(12) Independent review organization--An entity that is certified by the commissioner to conduct independent review under Insurance Code Article 21.58C and rules adopted by the commissioner.

(13) Life-threatening--Has the meaning assigned by Insurance Code Article 21.58A §2.

(14) Live--Where an employee lives includes:

(A) the employee's principal residence for legal purposes;

(B) a temporary residence necessitated by employment; or

(C) a temporary residence taken by the employee primarily for the purpose of receiving necessary assistance with routine daily activities because of a compensable injury.

(15) Medical emergency--The sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the patient's health or bodily functions in serious jeopardy; or

(B) serious dysfunction of any body organ or part.

(16) Medical records--The history of diagnosis and treatment for an injury, including medical, dental, and other health care records from each health care practitioner who provides care to an injured employee.

(17) Mental health emergency--A condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

(18) Network or workers' compensation health care network--An organization that is:

(A) formed as a health care provider network to provide health care services to injured employees;

(B) required to be certified in accordance with Insurance Code Chapter 1305, this chapter, and other rules of the commissioner as applicable; and

(C) established by, or operating under contract with, an insurance carrier.

(19) Nurse--Has the meaning assigned by Insurance Code Article 21.58A §2.

(20) Occupational medicine specialist--A doctor who has received a board certification in occupational medicine from the American Board of Preventive Medicine or who has completed all the requirements of the American Board of Preventive Medicine in order to take the board examination.

(21) Person--Any natural or artificial person, including an individual, partnership, association, corporation, organization, trust, hospital district, community mental health center, mental retardation center, mental health and mental retardation center, limited liability company, or limited liability partnership.

(22) Preauthorization--The process required to request approval from the insurance carrier or the network to provide a specific treatment or service before the treatment or service is provided.

(23) Provider--A health care provider.

(24) Quality improvement program--A system designed to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions.

(25) Retrospective review--The process of reviewing the medical necessity and reasonableness of health care that has been provided to an injured employee.

(26) Routine daily activities--Activities a person normally does in daily living, including sleeping, eating, bathing, dressing, grooming, and homemaking.

(27) Rural area--

(A) a county with a population of 50,000 or less;

(B) an area that is not designated as an urbanized area by the United States Census Bureau; or

(C) any other area designated as rural under rules adopted by the commissioner.

(28) Screening criteria--The written policies, medical protocols, and treatment guidelines used by an insurance carrier or a network as part of utilization review or retrospective review.

(29) Service area--A geographic area within which health care services from network providers are available and accessible to employees who live within that geographic area.

(30) Texas Workers' Compensation Act--Labor Code Title 5 Subtitle A.

(31) Transfer of risk--For purposes of this chapter only, an insurance carrier's transfer of financial risk for the provision of health care services to a network through capitation or other means.

(32) Utilization review--Has the meaning assigned by Insurance Code Article 21.58A §2.

(33) Utilization review agent--Has the meaning assigned by Insurance Code Article 21.58A §2.

(b) In this chapter, the following terms have the meanings assigned by Labor Code §401.011:

(1) administrative violation;

(2) case management;

(3) compensable injury;

(4) doctor;

(5) employer;

(6) evidence-based medicine;

(7) health care;

(8) health care facility;

(9) health care practitioner;

(10) health care provider;

(11) injury;

(12) insurance carrier; and

(13) treating doctor.

Subchapter B. Certification

§10.20. Certification Required.

(a) Except as provided by Labor Code §504.053(b)(2):

(1) A person may not operate or perform any act of a workers' compensation health care network in this state:

(A) unless the person holds a certificate issued under Insurance Code Chapter 1305 and this chapter, or

(B) except in accordance with the specific authorization of Insurance Code Chapter 1305 or this chapter.

(2) A person, including an insurance carrier, who provides or arranges to provide health care services to injured employees within a service area by contracting with more than one person, must be certified as a workers' compensation health care network under Insurance Code Chapter 1305 and this chapter.

(3) An entity performing any act of a workers' compensation health care network may not use in a network's name or in any informational literature distributed about a network any combination or variation of the words "workers' compensation," "certified," "managed care," or "network" to describe a network that is not certified in accordance with this chapter.

(b) Notwithstanding subsection (a)(1) and (2) of this section, this section does not apply to persons who contract with more than one person to provide or arrange to provide prescription medication or services, as defined by Labor Code §401.011(19)(E), to injured employees in the workers' compensation system.

§10.21. Certificate Application.

(a) A person who seeks a certificate to operate as a workers' compensation health care network must file an application on the forms prescribed under this subchapter, accompanied by a non-refundable fee of $5000.

(b) The applicant, an officer, or other authorized representative of the applicant must verify the application by attesting to the truth and accuracy of the information in the application.

(c) Prescribed forms for a certificate application may be obtained from:

(1) the department's website at www.tdi.state.tx.us; or

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

§10.22. Contents of Application. Each certificate application must include:

(1) a description or a copy of the applicant's basic organizational structure documents and other related documents, including organizational charts or lists that show:

(A) the relationships and contracts between the applicant and any affiliates of the applicant; and

(B) the internal organizational structure of the applicant's management and administrative staff;

(2) a completed biographical affidavit adopted by reference under §7.507(b) of this title (related to Forms Incorporated by Reference) from each person who governs or manages the affairs of the applicant, including the members of the governing board of the applicant, the chief executive officer, president, secretary, treasurer, chief financial officer and controller, and any other individuals with substantially similar responsibilities, provided that a biographical affidavit is not required if a biographical affidavit from the person is already on file with the department;

(3) a copy of the form of any contract between the applicant and any provider or group of providers as required under Insurance Code §§1305.151 -

1305.155 and §10.41 and §10.42 of this chapter (relating to Network-Carrier Contracts and Network Contracts with Providers);

(4) a copy of any agreement with any third party performing delegated functions on behalf of the applicant as required under Insurance Code §1305.154 and §10.41(a)(1) of this chapter.

(5) a copy of the form of each contract with an insurance carrier, as described by Insurance Code §1305.154 and §10.41 of this chapter;

(6) each management contract as described in §10.40 of this chapter (relating to Management Contracts), if applicable;

(7) a financial statement, current as of the date of the application that includes the most recent calendar quarter, prepared using generally accepted accounting principles, and including:

(A) a balance sheet that reflects a solvent financial position;

(B) an income statement;

(C) a cash flow statement;

(D) a statement of equity; and

(E) the sources and uses of all funds;

(8) a statement acknowledging that lawful process in a legal action or proceeding against the network on a cause of action arising in this state is valid if served in the manner provided by Insurance Code Chapter 804 for a domestic company;

(9) a description and a map of the applicant's service area or areas, with key and scale, that identifies each county, ZIP code, partial ZIP code, or part of a county to be served;

(10) a description of programs and procedures to be utilized, including:

(A) a complaint system, as required under Insurance Code §§1305.401 - 1305.405 and Subchapter G of this chapter (relating to Complaints);

(B) a quality improvement program, including return-to-work and medical case management programs, as required under Insurance Code §§1305.301 - 1305.304 and §10.81 of this chapter (relating to Quality Improvement Program);

(C) credentialing policies and procedures required under §10.82 of this chapter (relating to Credentialing);

(D) the utilization review and retrospective review programs described in Insurance Code §§1305.351 - 1305.355 and Subchapter F of this chapter (relating to Utilization Review and Retrospective Review), if applicable; and

(E) criteria and procedures for employees to select or change the employee’s treating doctor, including procedures for employees to select as the employee’s treating doctor a doctor who the employee selected, prior to injury, as the employee’s HMO primary care physician or provider;

(11) a description of the network configuration that demonstrates the adequacy of the network to provide comprehensive health care services sufficient to serve the population of injured employees within the service area and maps that demonstrate compliance with the access and availability standards under Insurance

Code §§1305.301 - 1305.304 and §10.80 of this chapter (relating to Accessibility and Availability Requirements). This description shall include, at a minimum, the following:

(A) names; addresses, including ZIP codes, specialty or specialties; board certifications, if any; professional license numbers; and hospital affiliations of network providers, including treating doctors, in sufficient number and specialty to provide all required health care services in a timely, effective, and convenient manner;

(B) names; addresses; federal employer identification number (FEIN); licenses; and types of health care facilities, including hospitals, rehabilitation facilities, diagnostic and testing facilities, ambulatory surgical centers, and interdisciplinary pain rehabilitation programs or interdisciplinary pain rehabilitation treatment facilities. The network must also demonstrate adequate access to emergency care;

(C) information indicating whether each network provider is accepting new patients from the workers' compensation health care network; and

(D) information indicating which network doctors are trained and certified to perform maximum medical improvement determinations and impairment rating services;

(12) the physical location of the applicant's books and records, including:

(A) financial and accounting records;

(B) investment records;

(C) organizational documents of the applicant; and

(D) minutes of all meetings of the applicant's governing board and executive or management committees;

(13) a business plan that describes the applicant's intended operations in this state, including both a narrative description and pro forma financial projections for the first two years of operation after certification;

(14) a completed financial authorization form sufficient to allow the department to confirm directly with appropriate financial institutions the reported assets of the applicant;

(15) the applicant's plan for provision of care to injured employees who live temporarily outside the service area, if applicable;

(16) the applicant's plan for provision of maximum medical improvement determinations and impairment rating services, including verification that the network doctors reported under paragraph (11)(D) of this section have completed the training required under Labor Code §408.023;

(17) the applicant's plan for verifying the filing by doctors and health care practitioners of the required financial disclosure with the division of workers' compensation under Labor Code §408.023 and §413.041;

(18) the form of the notice of network requirements and employee information, and the acknowledgment form required under Insurance Code §1305.005 and §10.60 of this chapter (relating to Notice of Network Requirements; Employee Information);

(19) the applicant's plan for monitoring whether providers have been provided and are following treatment guidelines, return-to-work guidelines, and individual treatment protocols as required under Insurance Code §1305.304 and §10.83 of this chapter (relating to Guidelines and Protocols);

(20) a description of treatment guidelines and return-to-work guidelines, and the network medical director's certification that the guidelines are evidence-based, scientifically valid, and outcome-focused as required under Insurance Code §1305.304 and §10.83(a) of this chapter; and

(21) a certification that:

(A) the network's medical director is an occupational medicine specialist; or

(B) the network employs or contracts with an occupational medicine specialist.

§10.23. Action on Application. The commissioner shall approve or disapprove an application for certification of a network in accordance with Insurance Code §1305.054.

§10.24. Network Financial Requirements.

(a) On at least a calendar year basis, each network shall prepare financial statements in accordance with generally accepted accounting principles which must include:

(1) a balance sheet;

(2) an income statement;

(3) a cash flow statement;

(4) a statement of equity; and

(5) a supplemental description of the network's basic organizational structure, general business relationships, and management.

(b) On or before April 1st of each year, each network shall provide the network's financial statement required by subsection (a) of this section to:

(1) each carrier with which the network contracts to facilitate carrier and network compliance under Insurance Code §§1305.154(c) and 1305.155 and §10.41 of this chapter (relating to Network-Carrier Contracts); and

(2) the department by sending the financial statement to the Texas Department of Insurance, Mail Code 103-6A, P.O. Box 149104, Austin, TX 78714-9104.

§10.25. Filing Requirements.

(a) After issuance of a network's certification, a network shall file with the department any information that amends, supplements, or replaces the items required under §10.22 of this chapter (relating to Contents of Application). The network shall file the information:

(1) as soon as practicable but not later than 30 days before implementation of any change requiring department approval, or

(2) no later than 30 days after the implementation of any other change.

(b) A network shall file with the department a written request for approval and must receive department approval before implementation of changes to the following:

(1) management contracts and information regarding fidelity bonds as described in Insurance Code §1305.102, including information regarding cancellation of fidelity bonds, new fidelity bonds, or amendments to fidelity bonds;

(2) the physical location of the network's books and records as described in §10.22(12) of this chapter;

(3) network configuration; and

(4) expansion, elimination, or reduction of an existing service area, or addition of a new service area.

§10.26. Modifications to Service Area.

(a) A network must file an application with and receive approval from the department before the network may expand, eliminate, or reduce an existing service area, or add a new service area. The application must be filed not later than 30 days before implementation of the modification. An officer, or other authorized representative of the network must verify the application by attesting to the truth and accuracy of the information in the application.

(b) An application for a service area modification must include:

(1) a description and a map with key and scale, showing both the currently approved service area and the proposed new service area, as required under §10.22(9) of this chapter (relating to Contents of Application);

(2) network configuration information, as required under §10.22(11) of this chapter; and

(3) separate and consolidated pro forma financial statements as described in §10.22(7) of this chapter for the existing network, the proposed new service area, and the proposed network.

(c) If an application for a service area modification changes any of the following items, the applicant must file the new item or any amendments to an existing item with the application filed under this section:

(1) a copy of the form of any new contracts or amendment of any existing contracts as described by and required under §10.22(3), (4) and (5) of this chapter;

(2) a brief narrative description of the administrative arrangements, organizational charts as required under §10.22(1) of this chapter, and other pertinent information;

(3) biographical data, on a form prescribed by the department, regarding each individual who governs or manages the affairs of the network as required under §10.22(2) of this chapter; and

(4) a copy of each management contract as described under §10.22(6) of this chapter.

(d) An application is not considered complete and reviewable until the department has received all information required under this section, including any additional information the department requests as needed to make that determination.

(e) Before the department considers a service area modification application, the applicant must be in good standing with the department and in compliance with all applicable requirements under this chapter, Insurance Code Chapter 1305, and Labor Code Title 5 in the existing service areas and in each proposed service area.

(f) A corrected notice of network requirements and employee information and acknowledgment form must be provided to affected employees.

(g) Prescribed application forms may be obtained from:

(1) the department's website at www.tdi.state.tx.us; or

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

§10.27. Modifications to Network Configuration.

(a) A network must file an application with and receive approval from the department before the network makes a material modification to its network configuration. The application must be filed not later than 30 days prior to implementation of the material modification.

(b) An application for a modification to network configuration must include:

(1) a description and a map of the network's service area or areas, with key and scale, that identifies each county, ZIP code, partial ZIP code, or part of a county to be served as required by §10.22 of this chapter (relating to Contents of Application); and

(2) network configuration information, as required by §10.22(11) of this chapter.

(c) The applicant must file a copy of the form of any new contracts or amendment of any existing contracts as described by and required under §10.22(3), (4) and (5) of this chapter if the modification of network configuration causes changes.

(d) An application is not considered complete and reviewable until the department has received all information required under this section, including any additional information the department requests as needed to make the determination.

(e) Before the department considers an application to modify a network's configuration, the applicant must be in good standing with the department and in compliance with all applicable requirements under this chapter, Insurance Code Chapter 1305, and Labor Code Title 5.

(f) Prescribed network configuration modification application forms may be obtained from:

(1) the department's website at www.tdi.state.tx.us; or

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

Subchapter C. Contracting

§10.40. Management Contracts.

(a) A network may not enter into a contract with another entity for management services, or modify a previously approved management contract, unless the proposed

contract or modification is first filed with the department and approved in accordance with this chapter.

(b) For purposes of this chapter, management services include management control and decision-making, and contracting on behalf of the network under a delegation of management authority, power of attorney or other arrangement.

§10.41. Network-Carrier Contracts.

(a) A network's contract with a carrier shall include the following:

(1) a description of the functions to be performed by the network or its delegated entity, consistent with the requirements of Insurance Code §1305.154(b), and the reporting requirements for each function;

(2) a statement that the network will perform all delegated functions in full compliance with all requirements of the Workers' Compensation Health Care Network Act, Insurance Code Chapter 1305, the Texas Workers' Compensation Act, Labor Code Title 5 Subtitle A and rules of the commissioner or the commissioner of workers' compensation;

(3) a provision that the contract:

(A) may not be terminated without cause by either party without 90 days' prior written notice; and

(B) must be terminated immediately if cause exists;

(4) a hold-harmless provision stating that the network, a management contractor, a third party to which the network delegates a function, and the network's

contracted providers are prohibited from billing or attempting to collect any amounts from an employee for health care services for compensable injuries under any circumstances, including the insolvency of the carrier or the network;

(5) a statement that the carrier retains ultimate responsibility for ensuring that all delegated functions and all management contractor functions are performed in accordance with applicable statutes and rules, and that the contract may not be construed to limit in any way the carrier's responsibility, including financial responsibility, to comply with all statutory and regulatory requirements;

(6) a statement that the network's role is to provide the services listed in Insurance Code §1305.154(b) as well as any other services or functions the carrier delegates, including functions delegated to a management contractor, subject to the carrier's oversight and monitoring of the network's performance;

(7) a requirement that the network provide the carrier, on at least a monthly basis and in a form that is usable for audit purposes, the data necessary for the carrier to comply with reporting requirements of the department and the division of workers' compensation of the department with respect to any services provided pursuant to the carrier-network contract, including the following data:

(A) last name, first name, date of injury, date of birth, sex, address, telephone number and social security number of each injured employee who is being served by the network, and name and license number of the injured employee's treating doctor;

(B) initial date of health care services delivered by the network for each employee; and

(C) any other data, as determined by the contract, necessary to assure proper monitoring of functions delegated to the network by the carrier;

(8) a requirement that the carrier, the network, any management contractor, and any third party to which the network delegates a function comply with a provision that requires the network to provide to the insurance carrier and department the license number of a management contractor or any delegated third party performing any function that requires a license under the Insurance Code or another insurance law of this state, including a license as a utilization review agent under Insurance Code Article 21.58A;

(9) a contingency plan under which the carrier would, in the event of termination of the contract or a failure to perform, reassume one or more functions of the network under the contract, including functions related to:

(A) payment to providers and notification to employees;

(B) quality of care;

(C) utilization review;

(D) retrospective review;

(E) continuity of care, including a plan for identifying and transitioning employees to new providers; and

(F) collecting and reporting of data necessary to comply with the reporting requirements described in paragraph (7) of this subsection;

(10) a provision that requires that any agreement by which the network delegates any function to a third party be in writing, and that such agreement require the delegated third party to be subject to all the requirements under Insurance Code Chapter 1305 and this subchapter;

(11) a provision that requires the network to provide to the department the license number of a management contractor or any delegated third party performing any function that requires a license under the Insurance Code or another insurance law of this state, including a license as a utilization review agent under Insurance Code Article 21.58A;

(12) an acknowledgement that:

(A) any management contractor or third party to whom the network delegates a function must comply with this chapter and other applicable statutes and rules, and that the management contractor or third party is subject to the carrier's and the network's oversight and monitoring of its performance; and

(B) if the management contractor or third party fails to meet monitoring standards established to ensure that functions delegated or assigned to the management contractor or third party under the delegation contract are in full compliance with all statutory and regulatory requirements, the carrier or network may cancel delegation of any or all delegated functions;

(13) a requirement that the network and any management contractor or third party to which the network delegates a function provide all necessary information

to allow the carrier to provide the information required by §10.60 of this chapter (relating to Notice of Network Requirements; Employee Information) to employers or employees;

(14) a provision that requires the network to require any third party with which it contracts, whether directly or through another third party, to permit the commissioner to examine at any time any information the commissioner believes is relevant to the third party's financial condition or the ability of the network to meet the network's responsibilities in connection with any function the third party performs or has been delegated.

(15) a requirement that the network:

(A) implement and maintain a complaint system in accordance with requirements under Insurance Code §1305.401 and §10.120 of this chapter (relating to Complaint System Required); and

(B) make the complaint log and complaint files available to the carrier upon request;

(16) a statement that the contract and any network contract with a provider, management contractor or other third party shall not be interpreted to involve a transfer of risk as defined under Insurance Code §1305.004(a)(26);

(17) a statement that any network contract with a provider or third party must allow the carrier to effect a contingency plan in the event that the carrier is required to resume functions from the network as contemplated under Insurance Code §1305.155; and

(18) a statement that any network contract with a provider or third party must comply with all applicable statutory and regulatory requirements under federal and state law.

(b) Except for the functions described under Insurance Code §1305.154(b) and §10.121 of this chapter (relating to Complaints; Deadlines for Responses and Resolution), a network's authority to perform a function under a network-carrier contract is conditioned upon whether:

(1) the carrier has delegated the function to the network by contract; and

(2) the network is appropriately licensed to perform the function.

(c) A network shall not act as a network for any entity regarding an insurance plan which is being operated in violation of Insurance Code §101.102.

§10.42. Network Contracts with Providers.

(a) A network is not required to accept an application for participation in the network from a health care provider that otherwise meets the requirements specified in this chapter if the network determines that the network has contracted with a sufficient number of qualified health care providers, including health care providers of the same license type or specialty.

(b) Provider contracts and subcontracts shall include, at a minimum, the following provisions:

(1) a hold-harmless clause stating that the provider and the provider network will not bill or attempt to collect any amounts of payment from an employee for

health care services for compensable injuries under any circumstances, including the insolvency of the insurance carrier or the network;

(2) a statement that the provider agrees to follow treatment guidelines, return-to-work guidelines and individual treatment protocols adopted by the network pursuant to §10.83 of this chapter (relating to Guidelines and Protocols), as applicable to an employee's injury;

(3) a provision that the network will not engage in retaliatory action, including termination of or refusal to renew a contract, against a provider because the provider has, on behalf of an employee, reasonably filed a complaint against, or appealed a decision of, the network, or requested reconsideration or independent review of an adverse determination;

(4) a continuity of treatment clause that states that:

(A) 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; and

(B) a dispute concerning continuity of care shall be resolved through the dispute resolution process under Insurance Code §§1305.401 - 1305.405 and Subchapter G of this chapter (relating to Complaints);

(5) a clause regarding appeal by the provider of termination of network provider status and applicable written notification to employees regarding such a termination, including requirements that:

(A) the network must provide notice to the provider at least 90 days before the effective date of a termination;

(B) the network must provide an advisory review panel that consists of at least three network providers of the same or similar specialty as the provider;

(C) upon receipt of the written notification of termination, a provider may request a review by the network's advisory review panel not later than 30 days after receipt of the notification;

(D) the network must complete the advisory panel review before the effective date of the termination;

(E) a network may not notify patients of the termination until the earlier of the effective date of the termination or the date the advisory review panel makes a formal recommendation;

(F) in the case of imminent harm to patient health, suspension or loss of license to practice, or fraud, the network may terminate the provider immediately and must notify employees immediately of the termination; and

(G) if the provider terminates the contract, the network must provide notification of the termination to employees receiving care from the terminating provider. The network shall give such notice immediately upon receipt of the provider's

termination request or as soon as reasonably possible before the effective date of termination;

(6) a provision that requires the provider to post, in the office of the provider, a notice to employees on the process for resolving workers' compensation health care network complaints in accordance with Insurance Code §1305.405. The notice must include the department's toll-free telephone number for filing a complaint and must list all workers' compensation health care networks with which the provider contracts;

(7) a statement that the network agrees to furnish to the provider, and the provider agrees to abide by, the list of any treatments and services that require the network's preauthorization and any procedures to obtain preauthorization;

(8) a statement that the contract and any subcontract within the provider network shall not be interpreted to involve a transfer of risk as defined under Insurance Code §1305.004(a)(26);

(9) a statement that the provider and any subcontracting provider within the provider network must comply with all applicable statutory and regulatory requirements under federal and state law;

(10) the schedule of fees that will be paid to the contracting provider;

(11) a statement specifying whether the provider whose specialty has been designated by the network as a treating doctor agrees to be a network treating doctor and, if so, any additional provisions applicable to the provider; and

(12) a statement that billing by and payment to the provider will be made in accordance with Labor Code §408.027 and other applicable statutes and rules.

(c) An insurance carrier and a network may not use any financial incentive or make a payment to a health care provider that acts directly or indirectly as an inducement to limit medically necessary services. The adoption of treatment guidelines, return-to-work guidelines, and individual treatment protocols by a network under Insurance Code §1305.304 and §10.83(a) of this chapter (relating to Guidelines and Protocols) is not a violation of this section.

(d) An insurance carrier or a network must provide written notice to a network provider or group of network providers before the carrier or network conducts any economic profiling, including utilization management studies comparing the provider to other providers, or other profiling of the provider or group of providers.

Subchapter D. Network Requirements

§10.60. Notice of Network Requirements; Employee Information.

(a) An insurance carrier that establishes or contracts with a network shall deliver to the employer, and the employer shall deliver to the employer's employees in the manner and at the times prescribed by Insurance Code §1305.005(d), (e), and (g):

(1) the notice of network requirements and employee information required by Insurance Code §§1305.005(d) and 1305.451 and this section; and

(2) the employee acknowledgment form described by Insurance Code §1305.005(d) and this section.

(b) An employee who lives within the service area of a network and who is being treated by a non-network provider for an injury that occurred before the employer's insurance carrier established or contracted with the network, shall select a network treating doctor or request a doctor who the employee selected, prior to the injury, as the employee's HMO primary care physician or provider, upon notification by the carrier that health care services are being provided through the network. The carrier shall provide to the employee all information required by Insurance Code §1305.451. The notice must include an employee acknowledgement form and all requirements under subsection (c) – (e) of this section.

(c) The notice of network requirements and employee acknowledgment form must be in:

(1) English, Spanish, and any other language common to 10 percent or more of the employer's employees; and

(2) a readable and understandable format that meets the plain language requirements under §10.63 of this chapter (relating to Plain Language Requirements).

(d) The insurance carrier and employer may use:

(1) an employee acknowledgment form that complies with this section; or

(2) a sample acknowledgment form that may be obtained from:

(A) the department's website at www.tdi.state.tx.us; or

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

(e) The employee acknowledgment form must include:

(1) a statement that the employee has received information that describes what the employee must do to receive health care under workers' compensation insurance;

(2) a statement that if the employee is injured on the job and lives in the service area described in the information, the employee understands that:

(A) the employee:

(i) must select a treating doctor from the list of doctors who contracted with the workers' compensation network, or

(ii) ask the employee's HMO primary care physician to agree to serve as the employee's treating doctor; and

(iii) obtain all health care and specialist referrals for a compensable injury through the treating doctor except for emergency services;

(B) the network provider will be paid by the insurance carrier and will not bill the employee for a compensable injury; and

(C) if the employee seeks health care from someone other than a network provider without network approval, the insurance carrier may not be liable, and the employee may be liable, for payment for that health care;

(3) separate lines for the employee to fill in the date and employee's signature, printed name and living address;

(4) a separate line that indicates the name of the employer; and

(5) a separate line that indicates the name of the network.

(f) The employer shall obtain a signed employee acknowledgment form from each employee.

(g) The notice of network requirements must comply with Insurance Code §§1305.005 and 1305.451 and include:

(1) a statement that the entity providing health care to employees is a certified workers' compensation health care network;

(2) the network's toll-free number and address for obtaining additional information about the network, including information about network providers;

(3) a description and map of the network's service area, with key and scale, that clearly identifies each county or ZIP code area or any parts of a county or ZIP code area that are included in the service area;

(4) a statement that an employee who does not live within the network's service area may notify the carrier as described under §10.62 of this chapter (relating to Dispute Resolution for Employee Requirements Related to In-Network Care);

(5) a statement that an employee who asserts that he or she does not currently live in the network's service area may choose to receive all health care services from the network during the pendency of the insurance carrier's review under §10.62 of this chapter and the pendency of the department's review of a complaint;

(6) a statement that, except for emergency services, the employee shall obtain all health care and specialist referrals through the employee's treating doctor;

(7) an explanation that network providers have agreed to look only to the network or insurance carrier and not to employees for payment of providing health care for a compensable injury, except as provided by paragraph (8) of this subsection;

(8) a statement that if the employee obtains health care from non-network providers without network approval, except for emergency care, the insurance carrier may not be liable, and the employee may be liable, for payment for that health care;

(9) information about how to obtain emergency care services, including emergency care outside the service area, and after-hours care;

(10) a list of the health care services for which the insurance carrier or network requires preauthorization or concurrent review;

(11) an explanation regarding continuity of treatment in the event of the termination from the network of a treating doctor;

(12) a description of the network's complaint system, including:

(A) a statement that an employee must file complaints with the network regarding dissatisfaction with any aspect of the network's operations or with network providers;

(B) any deadline for the filing of complaints, provided that the deadline may not be less than 90 days after the date of the event or occurrence that is the basis for the complaint;

(C) a single point of contact within the network for receipt of complaints, including the address and e-mail address of the contact; and

(D) a statement that the network is prohibited from retaliating against:

(i) an employee if the employee files a complaint against the network or appeals a decision of the network; or

(ii) a provider if the provider, on behalf of an employee, reasonably files a complaint against the network or appeals a decision of the network; and

(E) a statement explaining how an employee may file a complaint with the department as described under §10.122 of this chapter (relating to Submitting Complaints to the Department);

(13) a summary of the insurance carrier's or network's procedures relating to adverse determinations and the availability of the independent review process;

(14) a list of network providers updated at least quarterly, including:

(A) 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;

(B) a statement of limitations of accessibility and referrals to specialists; and

(C) a disclosure listing which providers are accepting new patients; and

(15) 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, but not later than 21 days after the date of the request.

(h) An employer shall deliver the notice of network requirements and acknowledgment form to the employer's employees and document the method of delivery, to whom the notice was delivered, and the date or dates of delivery. The failure of an employer to establish a standardized process for delivering to an employee a notice of network requirements and acknowledgment form for a network that has a service area in which the employee lives, including documentation of delivery of the notice and the date or dates of delivery, creates a rebuttable presumption that the employee has not received the notice of network requirements and is not subject to network requirements.

§10.61. Employees Who Live Within the Network Service Area, Employee Access and Insurance Carrier Liability for Health Care.

(a) The employees of an employer who elects to contract with an insurance carrier for network health care services, and who live within the network's service area, are required to obtain medical treatment for a compensable injury within the network, except as provided in Insurance Code §1305.006(1) and (3) and subsection (f)(1), (3) and (4) of this section.

(b) An employee is presumed to live at the physical address he or she has represented to the employer as his or her address or, if the employee no longer works for the employer, the physical address of record on file with the insurance carrier.

(c) At any time after the receipt of the notice of network requirements, an employee who no longer lives at the physical address described in subsection (b) of this section, or who otherwise asserts that he or she does not live in the network's service area, may notify the insurance carrier and request a review under §10.62 of this subchapter (relating to Dispute Resolution for Employee Requirements Related to In-Network Care).

(d) An employee who does not live within the network's service area may choose to participate in a network established by the insurance carrier or with which the insurance carrier has a contract upon mutual agreement between the employee and insurance carrier.

(e) An employee who is found to have fraudulently claimed to live outside the network's service area or made a material misrepresentation regarding where he or she lives and receives health care outside the network's service area may be liable for payment for that health care.

(f) An insurance carrier that establishes or contracts with a network is liable for in network health care for a compensable injury that is provided to an injured employee in accordance with Insurance Code Chapter 1305, and out-of-network care as follows:

(1) emergency care;

(2) health care provided to an injured employee 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;

(3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network as follows:

(A) if an injured employee's treating doctor requests a referral to an out-of-network provider for medically necessary health care services that are not available from network providers, the network shall approve or deny a referral to an out-of network provider within the time appropriate under the circumstances but, under any circumstance, not later than seven days after the date the referral is requested;

(B) if the network denies the referral request under subsection (a) of this section because the requested service is available from network providers, the employee may file a complaint in accordance with the network's complaint process under Insurance Code §1305.402 and §10.121 of this chapter (relating to Complaints; Deadlines for Response and Resolution);

(C) if the network denies the referral request under subparagraph (A) of this paragraph because the specialist referral is not medically necessary, the employee may file a request for independent review as described in §10.104 of this chapter (relating to Independent Review of Adverse Determination); and

(4) health care services provided to an injured employee before the employee received the notice of network requirements and the employee information for

the appropriate network under Insurance Code §1305.005(d), (e) or (g) and §10.60 of this chapter (relating to Notice of Network Requirements; Employee Information).

§10.62. Dispute Resolution for Employee Requirements Related to In-Network Care.

(a) If an employee asserts that he or she does not currently live in the network's service area, the employee may request a review by contacting the insurance carrier and providing evidence to support the employee's assertion.

(b) An insurance carrier shall review the employee's request for review, including any evidence provided by the injured employee and any evidence collected by the insurance carrier, and make a determination regarding whether the employee lives within the network's service area or lives within the service area of any other workers' compensation network contracted with or established by the insurance carrier (alternate network). If an insurance carrier makes a determination that the employee lives within the service area of an alternate network, the insurance carrier shall provide the employee with the notice of network requirements as described under §10.60 of this subchapter (relating to Notice of Network Requirements; Employee Information) for the alternate network. Upon receipt of the notice of network requirements, the employee must select a treating doctor from the list of the alternate network's treating doctors in the network's service area.

(c) Not later than seven calendar days after the date the insurance carrier receives notice of the injured employee's request for review, the insurance carrier shall

notify the employee, in writing, of the carrier's determination. This notice shall include a brief description of the evidence the carrier considered when making the determination, a copy of the carrier's determination and a description of how an employee may file a complaint regarding this issue with the department. The insurance carrier shall also send a copy of the carrier's determination to the employee's employer.

(d) If an employee disagrees with the insurance carrier's determination, the employee may file a complaint with the department in accordance with §10.122 of this chapter (relating to Submitting Complaints to the Department). To be considered complete, the employee's complaint must include:

(1) the employee's contact information, including the employee's name, current physical address, and telephone number;

(2) a copy of the insurance carrier's determination; and

(3) any evidence the employee provided to the insurance carrier for consideration.

(e) An injured employee who disputes whether he or she lives within the network's service area may seek all medical care from the network during the pendency of the insurance carrier's review and the department's investigation of a complaint.

§10.63. Plain Language Requirements.

(a) The notice of network requirements and employee information form and acknowledgment form required by Insurance Code §1305.451 and §10.60 of this

subchapter (relating to Notice of Network Requirements; Employee Information) shall be written in plain language and comply with the following requirements:

(1) the text shall achieve a minimum level of readability which may not be more difficult than the equivalent of a ninth grade reading level as measured by the Flesch reading ease test, a test referenced in the list of standardized tests contained in §3.3092(c)(1) of this title (relating to Format, Content, and Readability for Outline of Coverage), or other standardized test as approved by the department;

(2) the form shall be printed in not less than 12-point type;

(3) the form shall be appropriately divided and captioned in a meaningful sequence such that each section contains an underlined, boldfaced, or otherwise conspicuous title or caption at the beginning of the section that indicates the nature of the subject matter included in or covered by the section; and

(4) the form shall be written in a clear and coherent manner and wherever practical, words with common and everyday meanings shall be used to facilitate readability.

(b) The notice of network requirements and employee information form shall be accompanied by a certification signed by an officer or other authorized representative of the network stating the reading level of the form, the standardized test utilized to determine the reading level, and that the form meets or exceeds the minimum readability standards established by the commissioner. To confirm the accuracy of any certification, the commissioner may require the submission of additional information.

Subchapter E. Network Operations

§10.80. Accessibility and Availability Requirements.

(a) All services specified by this section must be provided by a provider who holds a current appropriate license, unless the provider is exempt from license requirements.

(b) The network shall ensure that the network's provider panel includes:

(1) an adequate number of treating doctors and specialists, who must be available and accessible to employees 24 hours a day, seven days a week, within the network's service area;

(2) sufficient numbers and types of health care providers to ensure choice, access, and quality of care to injured employees;

(3) an adequate number of the treating doctors and specialists who have admitting privileges at one or more network hospitals located within the network's service area to make any necessary hospital admissions;

(4) hospital services that are available and accessible 24 hours a day, seven days a week, within the network's service area. The network shall provide for the necessary hospital services by contracting with general, special, and psychiatric hospitals, as applicable;

(5) physical and occupational therapy services and chiropractic services that are available and accessible within the network's service area;

(6) emergency care that is available and accessible 24 hours a day, seven days a week, without restrictions as to where the services are rendered; and

(7) an adequate number of treating doctors who are qualified to provide maximum medical improvement and impairment rating services as required under Labor Code §408.023.

(c) Except for emergencies, a network shall arrange for services, including referrals to specialists, to be accessible to injured employees within the time appropriate to the circumstances and condition of the injured employee, but not later than 21 calendar days after the date of the original request.

(d) Each network shall provide that network services are sufficiently accessible and available as necessary to ensure that the distance from any point in the network's service area to a point of service by a treating doctor or general hospital is not greater than:

(1) 30 miles in nonrural areas; and

(2) 60 miles in rural areas.

(e) Each network shall provide that network services are sufficiently accessible and available as necessary to ensure that the distance from any point in the network's service area to a point of service by a specialist or specialty hospital is not greater than:

(1) 75 miles in nonrural areas; and

(2) 75 miles in rural areas.

(f) For portions of the service area in which the network or department identifies noncompliance with this section, the network must file an access plan with the department for approval at least 30 days before implementation of the plan if any health care service or a network provider is not available to an employee because:

(1) providers are not located within the required distances;

(2) the network is unable to obtain provider contracts after good faith attempts; or

(3) providers meeting the network's minimum quality of care and credentialing requirements are not located within the required distances.

(g) The access plan required under subsection (f) of this section must include:

(1) a description of the geographic area in which services or providers are not available, identified by county, city, ZIP code, mileage, or other identifying data;

(2) a map, with key and scale, which identifies the areas in which such health care services or providers are not available;

(3) for each geographic area identified as not having adequate health care services or providers available, the reason or reasons that health care services or providers cannot be made available;

(4) the network’s general plan for making health care services and providers available to injured employees in each geographic area identified, including:

(A) the names, addresses and specialties of the network providers and a listing of the services to be provided through the network that meet the health care needs of the employees;

(B) a listing of any health care services to be made available in the geographic area;

(C) a general description of the procedures to be followed by the network to assure that certain health care services are made available and accessible

to employees in the geographic areas identified as being areas in which the health care services or providers are not available and accessible; and

(D) a network development plan through which health care services or providers will be made available and accessible to employees in these geographic areas in the future;

(5) any other information which is necessary to allow the department to assess the network's access plan.

(h) The network may make arrangements with providers outside the service area to enable employees to receive a skill or specialty not available within the network service area.

(i) The network is not required to expand services outside the network's service area to accommodate employees who live outside the service area.

§10.81. Quality Improvement Program.

(a) A network shall develop and maintain continuous and comprehensive quality improvement program designed to monitor and evaluate objectively and systematically the quality and appropriateness of health care and network services, and to pursue opportunities for improvement. The quality improvement program shall include return-to-work and medical case management programs. The network shall dedicate adequate resources, including personnel and information systems, to the quality improvement program.

(b) Required documentation of the quality improvement program, at a minimum, includes:

(1) Written description. The network shall develop a written description of the quality improvement program that outlines program organizational structure, functional responsibilities, and committee meeting frequency;

(2) Work plan. The network shall develop an annual quality improvement work plan designed to reflect the type of services and the population served by the network in terms of age groups, disease or injury categories, and special risk status, such as type of industry. The work plan shall include:

(A) objective and measurable goals, planned activities to accomplish the goals, time frames for implementation, individuals responsible, and evaluation methodology;

(B) evaluation of each program, including:

(i) network adequacy, which encompasses availability and accessibility of care and assessment of providers who are and are not accepting new patients;

(ii) continuity of health care and related services;

(iii) clinical studies;

(iv) the adoption and periodic updating of treatment guidelines, return-to-work guidelines, individual treatment protocols and the list of services requiring preauthorization;

(v) employee and provider satisfaction;

(vi) the complaint and appeal process, complaint data, and identification and removal of communication barriers which may impede employees and providers from effectively making complaints against the network;

(vii) provider billing processes, if applicable;

(viii) contract monitoring, including delegation oversight, if applicable, and compliance with filing requirements;

(ix) utilization review and retrospective review processes, if applicable;

(x) credentialing;

(xi) employee services, including after-hours telephone access logs;

(xii) return-to-work processes and outcomes; and

(xiii) medical case management outcomes;

(3) Annual evaluation. The network shall prepare an annual written report on the quality improvement program, which includes:

(A) completed activities;

(B) trending of clinical and service goals;

(C) analysis of program performance; and

(D) conclusions regarding the effectiveness of the program.

(c) The network is presumed to be in compliance with statutory and regulatory requirements regarding quality improvement requirements, including credentialing, if:

(1) the network has received nonconditional accreditation or certification by the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Accreditation HealthCare Commission (URAC), or the Accreditation Association for Ambulatory Health Care (AAAHC), or any other national accreditation entity recognized by rules adopted by the commissioner of insurance;

(2) the accreditation includes all quality improvement requirements set forth in this section;

(3) the certification for a function, including credentialing, includes all requirements set forth in this section; and

(4) the national accreditation organization's requirements are the same, substantially similar to, or more stringent than the department's quality improvement requirements.

(d) The network governing body is ultimately responsible for the quality improvement program and shall:

(1) appoint a quality improvement committee that includes network providers;

(2) approve the quality improvement program;

(3) approve an annual quality improvement work plan;

(4) meet no less than annually to receive and review reports of the quality improvement committee or group of committees, and take action when appropriate; and

(5) review the annual evaluation of the quality improvement program.

(e) The quality improvement committee shall evaluate the overall effectiveness of the quality improvement program. The committee may delegate and oversee quality improvement activities to subcommittees that may, if applicable, include practicing doctors and employees from the service area. All subcommittees shall:

(1) collaborate and coordinate efforts to improve the quality, availability, and accessibility of health care services; and

(2) meet regularly and routinely report findings, recommendations, and resolutions in writing to the quality improvement committee for the network.

(f) The network shall have a medical case management program with certified case managers whose certifying organization must be accredited by an established accrediting organization, including the National Commission for Certifying Agencies (NCCA), the American Board of Nursing Specialties, or another national accrediting agency with similar standards. In accordance with Labor Code §413.021(a), a claims adjuster may not serve as a case manager. The case manager shall work with providers, employees, doctors and employers to facilitate cost-effective health care and the employee's return to work, and must be certified in one or more of the following areas:

(1) case management;

(2) case management administration;

(3) rehabilitation case management;

(4) continuity of care;

(5) disability management; or

(6) occupational health.

§10.82. Credentialing.

(a) Process for selection and retention of network doctors and health care practitioners.

(1) A network shall implement a documented process for selection and retention of contracted doctors and health care practitioners including the following elements, as applicable:

(A) The network's policies and procedures shall clearly indicate the doctor or health care practitioner directly responsible for the credentialing program and shall include a description of his or her participation.

(B) Networks shall develop written criteria for credentialing of doctors and health care practitioners and written procedures for verifications, including verification that the doctor or health care practitioner filed financial disclosure information with the department's division of workers' compensation in accordance with Labor Code §§408.023 and 413.041.

(i) The network shall credential all doctors and health care practitioners, including advanced practice nurses and physician assistants, if they are listed in the provider directory. A network shall credential each doctor and health care practitioner who is a member of a contracting group, such as an independent doctor association or medical group.

(ii) The network's policies and procedures must include the following doctors' and health care practitioners' rights:

(I) the right to review information submitted to support the credentialing application;

(II) the right to correct erroneous information;

(III) the right, upon request, to be informed of the status of the credentialing or recredentialing application; and

(IV) the right to be notified of these rights.

(iii) A network is not required to credential:

(I) hospital-based doctors or health care practitioners, including advanced practice nurses and physician assistants unless listed in the provider directory;

(II) health care practitioners who furnish services only under the direct supervision of a doctor or another health care practitioner except as specified in subparagraph (B)(i) of this paragraph;

(III) students, residents, or fellows;

(IV) pharmacists; or

(V) opticians.

(iv) A network must complete the initial credentialing process, including application, verification of information, and a site visit (if applicable), before the effective date of the initial contract with the doctor or health care practitioner.

(v) The network's policies and procedures shall include a provision that applicants be notified of the credentialing decision no later than 60 calendar days after the credentialing committee's decision.

(vi) A network must have written policies and procedures for suspending or terminating affiliation with a contracting doctor or health care practitioner.

(vii) The network shall have a procedure for the ongoing monitoring of doctor and health care practitioner performance between periods of recredentialing and shall take appropriate action when it identifies occurrences of poor quality. Monitoring shall include:

(I) Medicare and Medicaid sanctions: the network must determine the publication schedule or release dates applicable to its doctor and health care practitioner community; the network is responsible for reviewing the information within 30 calendar days of its release;

(II) information from state licensing boards regarding sanctions or licensure limitations;

(III) complaints; and

(IV) information from the department's division of workers' compensation regarding sanctions or practice limitations.

(viii) The network's procedures shall ensure that selection and retention criteria do not discriminate against doctors or health care practitioners who serve high-risk populations or who specialize in the treatment of costly conditions. Procedures shall also include a provision that credentialing and recredentialing

decisions are not based on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures performed or types of patients.

(I) The network shall have a procedure for notifying licensing or other appropriate authorities, including the department's division of workers' compensation, when a doctor's or health care practitioner's affiliation is suspended or terminated due to quality of care concerns.

(II) The network shall maintain evidence of notification as required under subclause (I) of this clause.

(C) The initial credentialing process for doctors and health care practitioners must include the following:

(i) Doctors and health care practitioners shall complete an application which includes a work history covering at least the immediately preceding five years, a statement by the applicant regarding any limitations in ability to perform the functions of the position, history of loss of license and/or felony convictions; and history of loss or limitation of privileges, sanctions or other disciplinary activity, current use of illegal drugs, current professional liability insurance coverage information, and information on whether the doctor or health care practitioner will accept new patients from the network. A network may use the standardized credentialing application form specified in §21.3201 of this title (relating to Texas Standardized Credentialing Application for Physicians, Advanced Practice Nurses and Physician Assistants) for credentialing of health care practitioners. The completion date on the application shall

be within 180 calendar days prior to the date the credentialing committee deems a doctor or health care practitioner eligible for initial credentialing.

(ii) The network shall verify the following from primary sources and shall include evidence of verification in the credentialing files:

(I) A current license to practice in the State of Texas and information on sanctions or limitations on licensure. The primary source for verification shall be the state licensing agency or board for Texas, and the license and sanctions must be verified within 180 calendar days prior to the date the credentialing committee deems a doctor or health care practitioner eligible for initial credentialing. The license must be in effect at the time of the credentialing decision.

(II) Education and training, including evidence of graduation from an appropriate professional school and completion of a residency or specialty training, if applicable. Primary source verification shall be sought from the appropriate schools and training facilities or the American Medical Association MasterFile. If the state licensing board, agency, or specialty board verifies education and training with the doctor's or health care practitioner’s schools and facilities, evidence of current state licensure or board certification shall also serve as primary source verification of education and training.

(III) Board certification, if the doctor or health care practitioner indicates that he/she is board certified on the application. The network may obtain primary source verification from the American Board of Medical Specialties Compendium, the American Osteopathic Association, the American Medical Association

MasterFile, or from the specialty boards, and the network must use the most recent available source.

(IV) A valid DEA or DPS Controlled Substances Registration Certificate, if applicable in effect at the time of the credentialing decision. The network may verify the certificate(s) by any one of the following means:

(-a-) a copy of the DEA or DPS certificate;

(-b-) visual inspection of the original certificate;

(-c-) confirmation with DEA or DPS;

(-d-) confirmation of entry in the National Technical Information Service database; or

(-e-) confirmation of entry in the American Medical Association Physician MasterFile.

(iii) The network shall verify within 180 calendar days prior to the date of the credentialing decision and shall include in the doctor's or health care practitioner's credentialing file the following:

(I) past five-year history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the doctor or health care practitioner, which the network may obtain from the professional liability carrier or the National Practitioner Data Bank; and

(II) information on previous sanction activity by Medicare and Medicaid which the network may obtain from one of the following:

(-a-) National Practitioner Data Bank;

(-b-) Cumulative Sanctions Report available over the internet;

(-c-) Medicare and Medicaid Sanctions and Reinstatement Report distributed to federally contracting networks;

(-d-) state Medicaid agency or intermediary and the Medicare intermediary;

(-e-) Federation of State Medical Boards;

(-f-) Federal Employees Health Benefits Program department record published by the Office of Personnel Management, Office of the Inspector General; or

(-g-) entry in the American Medical Association Physician MasterFile.

(iv) The network shall perform a site visit to the offices of each treating doctor as part of the initial credentialing process. If doctors or health care practitioners are part of a group practice that shares the same office, the network may perform one visit to the site for all doctors or health care practitioners in the group practice, as well as for new doctors or health care practitioners who subsequently join the group practice. The network shall make the site visit assessment available to the department for review. The network shall have a process to track the relocation of and the opening of additional office sites for treating doctors as they open.

(v) Site visits shall consist of an evaluation of the site's accessibility, appearance, appointment availability, and space, using standards

approved by the network. If a treating doctor offers services that require certification or licensure, such as laboratory or radiology services, the treating doctor shall have the current certification or licensure available for review at the site visit. In addition, as a result of the site visits, the network shall determine whether the site conforms to the network's standards for record organization, documentation, and confidentiality practices. Should the site not conform to the network's standards, the network shall require a corrective action plan and perform a follow-up site visit every six months until the site complies with the standards.

(D) The network shall have written procedures for recredentialing doctors and health care practitioners at least every three years through a process that updates information obtained in initial credentialing.

(i) Recredentialing will include a current and signed attestation that must be completed within 180 days prior to the date the credentialing committee deems a doctor or health care practitioner eligible for recredentialing with the following factors:

(I) reasons for any inability to perform the essential functions of the position, with or without accommodation;

(II) lack of current use of illegal drugs;

(III) history of loss or limitation of privileges or disciplinary activity;

(IV) current professional liability insurance coverage; and

(V) correctness and completeness of the application.

(ii) Recredentialing procedures must be completed within 180 days prior to the date the credentialing committee deems a doctor or health care practitioner eligible for recredentialing and shall include the following processes:

(I) reverification of the following from the primary sources:

(-a-) licensure and information on sanctions or limitations on licensure;

(-b-) board certification:

(-1-) if the doctor or health care practitioner was due to be recertified; or

(-2-) if the doctor or health care practitioner indicates that he or she has become board certified since the last time he or she was credentialed or recredentialed; and

(-c-) Drug Enforcement Agency (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate, if applicable. The network may reverify the certificate(s) by any one of the following means:

(-1-) a copy of the DEA or DPS certificate;

(-2-) visual inspection of the original certificate;

(-3-) confirmation with DEA or DPS;

(-4-) confirmation of entry in the National Technical Information Service database; or

(-5-) confirmation of entry in the American Medical Association Physician MasterFile;

(ll) review of updated history of professional liability claims in accordance with the verification sources and time limits specified in subparagraph (C)(iii) of this paragraph.

(E) The credentialing process for institutional providers shall include the following:

(i) evidence of state licensure;

(ii) evidence of Medicare certification;

(iii) evidence of other applicable state or federal requirements, e.g., Bureau of Radiation Control certification for diagnostic imaging centers, certification for community mental health centers from the Texas Department of Mental Health and Mental Retardation or its successor agency, CLIA (Clinical Laboratory Improvement Amendments of 1988) certification for laboratories;

(iv) evidence of accreditation by a national accrediting body, as applicable; the network shall determine which national accrediting bodies are appropriate for different types of institutional providers. The network's written policies and procedures must state which national accrediting bodies it accepts; and

(v) evidence of on-site evaluation of the institutional provider against the network's written standards for participation if the provider is not accredited by the national accrediting body required by the network.

(F) The network procedures shall provide for recredentialing of institutional providers at least every three years through a process that updates information obtained for initial credentialing as set forth in subparagraph (E)(i) - (v) of this paragraph.

(2) The network or the network's delegated entity shall make all credentialing processes and files available to the department upon request.

(b) Site visits for cause.

(1) The network shall have procedures for detecting deficiencies subsequent to the initial site visit. When the network identifies new deficiencies, the network shall reevaluate the site and institute actions for improvement.

(2) A network may conduct a site visit to the office of any doctor or health care practitioner at any time for cause. The network shall conduct the site visit to evaluate the complaint or other precipitating event, which may include an evaluation of any facilities or services related to the complaint or event and an evaluation of medical records, equipment, space, accessibility, appointment availability, or confidentiality practices, as appropriate.

(c) Peer review. The quality improvement program shall provide for a peer review procedure for doctors, as required under the Medical Practice Act, Chapters 151-164, Occupations Code. The network shall designate a credentialing committee that

uses a peer review process to make recommendations regarding credentialing decisions.

(d) Delegation of credentialing.

(1) If the network delegates credentialing functions to other entities, it shall have:

(A) a process for developing delegation criteria and for performing pre-delegation and annual audits;

(B) a delegation agreement;

(C) a monitoring plan; and

(D) a procedure for termination of the delegation agreement for non-performance.

(2) If the network delegates credentialing functions to an entity accredited by the NCQA, the annual audit of that entity is not required for the function(s) listed in the NCQA accreditation; however, evidence of this accreditation shall be made available to the department for review.

(3) The network shall maintain:

(A) documentation of pre-delegation and annual audits;

(B) executed delegation agreements;

(C) semi-annual reports received from the delegated entities;

(D) evidence of evaluation of the reports;

(E) current rosters or copies of signed contracts with doctors and health care practitioners who are affected by the delegation agreement; and

(F) documentation of ongoing monitoring and shall make it available to the department for review.

(4) Credentialing files maintained by the other entities to which the network has delegated credentialing functions shall be made available to the department for examination upon request.

(5) In all cases, the network shall maintain the right to approve credentialing, suspension, and termination of doctors and health care practitioners.

§10.83. Guidelines and Protocols.

(a) 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.

(b) An insurance carrier or network may not deny treatment for a compensable injury solely because its treatment guidelines do not specifically address the treatment or injury.

(c) A network shall, through its quality improvement program under §10.81 of this subchapter (relating to Quality Improvement Program), assure that all treatment guidelines, return-to-work guidelines, and individual treatment protocols are made available to all network providers. The network shall contractually require providers to follow treatment guidelines, return-to-work guidelines and individual treatment protocols pursuant to §10.42(b)(2) of this chapter (relating to Network Contracts with Providers).

§10.84. Treating Doctor. In addition to the duties and requirements placed upon treating doctors under Insurance Code Chapter 1305 and this chapter, a doctor designated as a treating doctor by a network shall comply with Labor Code §§408.0041(c) and (g), 408.025(c), and 408.023(l) - (p) and rules adopted by the commissioner of workers' compensation.

§10.85. Selection of Treating Doctor; Change of Treating Doctor.

(a) Selection of treating doctor. An injured employee who lives within the service area is entitled to the employee's initial choice of a treating doctor from the list provided by the network of all treating doctors under contract with the network who provide services within the service area in which the injured employee lives in accordance with Insurance Code §1305.104(a).

(b) Change of treating doctor. An injured employee who is dissatisfied with the employee's initial choice of treating doctor or with an alternate treating doctor may select an alternate or subsequent treating doctor in accordance with Insurance Code §1305.104(b) – (e).

(c) Use of specialist as treating doctor. An injured employee with a chronic, life-threatening injury or chronic pain related to a compensable injury may apply to the network's medical director to use a treating doctor specialist that is in the same network as the injured employee's treating doctor in accordance with Insurance Code §1305.104(f) – (i).

(d) Request for an HMO primary care physician or provider as the employee's treating doctor. An employee who is a member of an HMO at the time of the employee's work-related injury, may request that the employee's HMO primary care physician or provider who the employee selected prior to the injury serve as that employee's treating doctor in the workers' compensation health care network in accordance with Insurance Code §1305.105. The network shall grant a employee's request for an HMO primary care physician or provider to serve as the employee's treating doctor if the physician or provider agrees to abide by the terms of the network's contract and comply with Insurance Code Chapter 1305, Subchapters D through I and commissioner rules adopted under those subchapters.

§10.86. Telephone Access. Each network shall establish and maintain telephone access logs for calls received other than during regular business hours that accurately record the following:

(1) the date the network received the telephone call;

(2) detailed information necessary for the network to respond to the telephone call;

(3) the date the network responded to the telephone call; and

(4) identifying information for the telephone call.

Subchapter F. Utilization Review and Retrospective Review

§10.100. Applicability. In addition to the requirements under this subchapter, the requirements of Insurance Code Article 21.58A apply to utilization review conducted in relation to a workers' compensation health care network. In the event Article 21.58A conflicts with this chapter and Insurance Code Chapter 1305, this chapter and Insurance Code Chapter 1305 control.

§10.101. General Standards for Utilization Review and Retrospective Review.

(a) Screening criteria used for utilization review and retrospective review related to a workers' compensation health care network must be consistent with the network's treatment guidelines, return-to-work guidelines, and individual treatment protocols.

(b) The carrier's utilization review program must include a process requiring a treating doctor or specialist to request approval from the network for deviation from the treatment guidelines, screening criteria and individual treatment protocols where required by the particular circumstances of an employee's injury.

§10.102. Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements.

(a) The preauthorization requirements of Labor Code §413.014 and rules adopted under that section do not apply to health care provided through a workers' compensation network. If a carrier or network uses a preauthorization process within a network, the requirements of Insurance Code §§1305.351 - 1305.355 and this chapter apply.

(b) Any person performing utilization review or retrospective review for an injured employee receiving health care services in a network shall notify the employee or the employee's representative, if any, and the requesting provider of a determination made in a utilization review or retrospective review.

(c) Notification of an adverse determination must include:

(1) the principal reasons for the adverse determination;

(2) the clinical basis for the adverse determination;

(3) a description of or the source of the screening criteria that were used as guidelines in making the determination;

(4) for any provider consulted, the professional specialty and a validation that the provider is licensed in Texas in accordance with Labor Code §408.0231(g);

(5) a description of the procedure for the reconsideration process; and

(6) notification of the availability of independent review in the form prescribed by the commissioner.

(d) On receipt of a preauthorization request from a provider for proposed services that require preauthorization, the person performing utilization review must issue and transmit a determination indicating whether the proposed health care services are preauthorized, and respond to requests for preauthorization within the periods prescribed by this section.

(e) If the proposed services are for concurrent hospitalization care, the person performing utilization review must, within 24 hours of receipt of the request, transmit a determination indicating whether the proposed services are preauthorized.

(f) If the proposed health care services involve post-stabilization treatment or a life-threatening condition, the person performing utilization review must transmit to the requesting provider a determination indicating whether the proposed services are preauthorized within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, not to exceed one hour from receipt of the request. If the person performing utilization review issues an adverse determination in response to a request for post-stabilization treatment or a request for treatment involving a life-threatening condition, the person performing utilization review must provide to the employee or the employee's representative, if any, and the employee's treating provider the notification required under subsection (b) of this section.

(g) For all other requests for preauthorization or retrospective review, the person performing utilization review or retrospective review must issue and transmit the determination under subsection (d) of this section not later than the third calendar day after the date the request is received.

(h) Prescribed forms related to the availability of independent review may be obtained from:

(1) the department's website at www.tdi.state.tx.us; or

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

§10.103. Reconsideration of Adverse Determination.

(a) A person who performs utilization review or retrospective review shall maintain and make available a written description of the reconsideration procedures involving an adverse determination. The reconsideration procedures must be reasonable and include:

(1) a provision stating that a provider other than the provider who made the original adverse determination must perform the reconsideration;

(2) a provision that an employee, a person acting on behalf of the employee, or the employee's requesting provider may, not later than the 30th day after the date of issuance of written notification of an adverse determination, request reconsideration of the adverse determination either orally or in writing;

(3) a provision that, not later than the fifth calendar day after the date of receipt of the request for reconsideration, the person performing utilization review or retrospective review must send to the requesting party a letter acknowledging the date of the receipt of the request that includes a reasonable list of documents the requesting party is required to submit;

(4) a provision that, after completion of the review of the request for reconsideration of the adverse determination, the person performing utilization review or retrospective review must issue a response letter to the employee or person acting on behalf of the employee, and the employee's requesting provider, that:

(A) explains the resolution of the reconsideration; and

(B) includes:

(i) a statement of the specific medical or clinical reasons for the resolution;

(ii) the medical or clinical basis for the decision;

(iii) for any provider consulted, the professional specialty and state(s) in which the provider is licensed; and

(iv) notice of the requesting party's right to seek review of the denial by an independent review organization and the procedures for obtaining that review in the form of notice referenced in §10.102(h) of this subchapter (relating to Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements); and

(5) written notification to the requesting party of the determination of the request for reconsideration as soon as practicable, but not later than the 30th day after the date the person performing utilization review or retrospective review received the request.

(b) In addition to the requirements in subsection (a) of this section, the reconsideration procedures must include:

(1) a method for expedited reconsideration procedures for:

(A) denials of proposed health care services involving post-stabilization treatment;

(B) life-threatening conditions; and

(C) denials of continued stays for hospitalized employees;

(2) a review by a provider who has not previously reviewed the case and who is of the same or a similar specialty as a provider who typically manages the condition, procedure, or treatment under review; and

(3) a provision that the period during which the reconsideration is to be completed must be based on the medical or clinical immediacy of the condition, procedure, or treatment, but may not exceed one calendar day from the date of receipt of all information necessary to complete the reconsideration.

(c) Notwithstanding subsection (a) or (b) of this section, an employee with a life-threatening condition is entitled to an immediate review by an independent review organization and is not required to comply with the procedures for a reconsideration of an adverse determination.

§10.104. Independent Review of Adverse Determination.

(a) The person who performs utilization review or retrospective review, denies a referral request because the referral is not medically necessary, or denies a request for deviation from treatment guidelines, individual treatment protocols or screening criteria, must:

(1) permit the employee, person acting on behalf of the employee, or the employee's requesting provider to seek review of the referral denial or reconsideration denial within the period prescribed by subsection (b) of this section by an independent review organization assigned in accordance with Insurance Code Article 21.58C and commissioner rules; and

(2) provide to the appropriate independent review organization, not later than the third business day after the date the person receives notification of the assignment of the request to an independent review organization:

(A) any medical records of the employee that are relevant to the review;

(B) any documents, including treatment guidelines, used by the person in making the determination;

(C) the response letter described by Insurance Code §1305.354(a)(4) and §10.103(a)(4) of this chapter (relating to Reconsideration of Adverse Determination);

(D) any documentation and written information submitted in support of the request for reconsideration; and

(E) a list of the providers who provided care to the employee and who may have medical records relevant to the review.

(b) A requestor must timely file a request for independent review under subsection (a) of this section as follows:

(1) for a request regarding preauthorization or concurrent review, not later than the 45th day after the date of denial of a reconsideration; or

(2) for a request regarding retrospective medical necessity review, not later than the 45th day after the denial of reconsideration.

(c) The insurance carrier must pay for the independent review provided under this subchapter.

(d) The department shall assign the review request to an independent review organization.

(e) At a minimum, the decision of the independent review organization must include the elements listed and the certification required under Labor Code §413.032.

(f) After an independent review organization's review and decision under this section, a party to a medical dispute that disputes the decision may seek judicial review of the decision. The division of workers' compensation and the department are not considered to be parties to the medical dispute.

(g) A decision of an independent review organization related to a request for preauthorization or concurrent review is binding. The carrier is liable for health care during the pendency of any appeal, and the carrier and network shall comply with the decision.

(h) If judicial review is not sought under this section, the carrier and network shall comply with the independent review organization's decision.

(i) Judicial review under this section shall be conducted in the manner provided for judicial review of contested cases under Subchapter G, Chapter 2001, Government Code.

Subchapter G. Complaints

§10.120. Complaint System Required. Each network shall implement and maintain a complaint system compliant with Insurance Code §§1305.401 - 1305.405 and this

subchapter that provides reasonable procedures for resolving an oral or written complaint.

§10.121. Complaints; Deadlines for Response and Resolution.

(a) Not later than seven calendar days after receipt of an oral or written complaint, the network must:

(1) acknowledge receipt of the complaint in writing;

(2) acknowledge the date of receipt; and

(3) provide a description of the network's complaint procedures and deadlines.

(b) A network shall investigate each complaint received in accordance with the network's policies and in compliance with this subchapter.

(c) After a network has investigated a complaint, the network shall issue a resolution letter to the complainant not later than the 30th day after the network receives the written complaint which:

(1) explains the network's resolution of the complaint;

(2) states the specific reasons for the resolution;

(3) states the specialization of any health care provider consulted; and

(4) states that, if the complainant is dissatisfied with the resolution of the complaint or the complaint process, the complainant may file a complaint with the department as described in §10.122 of this subchapter (relating to Submitting Complaints to the Department).

(d) A network shall maintain a complaint log regarding each complaint and categorize each complaint as one or more of the following:

(1) quality of care or services;

(2) accessibility and availability of services or providers;

(3) utilization review and retrospective review, as applicable;

(4) complaint procedures;

(5) health care provider contracts;

(6) bill payment, as applicable;

(7) fee disputes; and

(8) miscellaneous.

(e) Each network must maintain the complaint log required under subsection (d) of this section and documentation on each complaint, complaint proceeding, and action taken on the complaint until the third anniversary after the date the complaint was received.

§10.122. Submitting Complaints to the Department.

(a) Any person, including a person who has attempted to resolve a complaint through a network's complaint system process or attempted to resolve a dispute regarding whether the employee lives within the network's service area through the insurance carrier, who is dissatisfied with resolution of the complaint, may submit a complaint to the department.

(b) The department's complaint form may be obtained from:

(1) the department's website at www.tdi.state.tx.us; or

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

8. CERTIFICATION. This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued at Austin, Texas, on _____, 2005.

_____
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance