ADVISORY NO. 383
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TOPIC: SUMMARY OF PROPOSED NETWORK RULES

Title 28: Part I: Chapter 10

Subchapter A: General Provisions and Definitions

10.1. Purpose and Scope.

Defines who may organize a network. Subsection (d) reiterates the staff proposal prohibiting employer contracts with networks.

10.2. Definitions.

This section proposes thirty-three definitions unique to the Insurance Code. Preauthorization is now defined generally as a process required for requesting approval to provide a specific treatment within the network. Remember that preauthorization within a network will not be governed by Rule 134.600. That rule will only apply to non-network care.

Includes definitions clarifying how to determine where claimant lives for the purposes of network care, and what constitutes the network's service area.

Subchapter B: Certification

10.20 Certification Required.

Except for political subdivisions and pharmacy benefit managers, no one may “operate or perform any act of a workers’ compensation health network” unless the person holds a certificate. The statute clearly provides that a carrier and a network may negotiate the functions to be provided by the network. §1305.154(b) TEX.INS.CODE. See also Proposed Rule 10.41. This section otherwise prohibits misleading terminology in a network name.

10.21. Certificate Application.

Requires a $5,000 non-refundable fee, a verified application, and completion of prescribed forms.

10.22. Contents of Application.

Prescribes the application content. It dispenses with the requirement for fingerprints included in the earlier informal draft. It does continue to require extensive financial disclosure and the

business plan of the network, including maps of service area, protocols for selection and deletion of doctor, etc.

10.23. Action on Application.
Adopts the HB 7 standard for approval of the application within sixty (60) days.

10.24. Network Financial Requirements.
On at least a calendar-year basis, each network must file a balance sheet, income statement, cash flow statement, statement of equity, and supplement the description of the networks structure, business relationships and management contained in the original application. The financial requirements will be required each April 1st.

10.25. Filing Requirements.
After certification, changes or amendments in the network plan of operation as described in the rule must be communicated to the Department within thirty (30) days of the change.

10.26. Modification of Service Area.
Requires the network to apply and receive approval before expanding or reducing the service area.

10.27. Modifications to Network Configuration.
Requires the network to apply and receive approval before materially modifying its network the identity of network providers, the various medical specialties within the network, and or the medical facilities in general.

Subchapter C: Contracting

10.40. Management Contracts.
Network must file and obtain approval for any contract with another entity for management services.

10.41. Network -Carrier Contracts.
This is a very important section of the Rules and should be reviewed carefully.

This rule contains specific requirements for a contract between a carrier and a network. It specifically refers to "functions to be performed by the network or its delegated entity" consistent with HB 7 permitting contracts between carriers and networks about functions to be provided with the network.

Contract must provide for 90 notice of termination without cause, immediately with cause (the

immediate termination was added pursuant to comment).

Carrier is ultimately responsible for all delegated functions and provides for information sharing, etc.

Network must provide a data file on a monthly basis sufficient to comply with the reporting requirements of TDI, including identification of all persons "served by the network." Serve is not defined.

It specifically acknowledges that a network may delegate utilization review functions to a URA.

10.42. Network Contracts with Providers.
Specifically acknowledges the statutory discretion for a network to refuse to accept any provider if the network determines it has a sufficient number of qualified providers of the same license type or specialty.

Prescribes extensive requirements for provider contracts and subcontracts including:

(3) Prohibition against network retaliation against a provider because of a complaint, an appeal of a network decision, or other adverse determination. (*This could create a risk for potential litigation in the event of a removal of a physician from the network.)*

(5) Provisions for 90 day notice of termination of a provider's status in the network and an appeal by a provider of a termination of network provider status

Insurance carriers and networks may not create financial incentives to limit medically necessary services.

Subsection B clarifies the current confusion about employees injured prior to the adoption of a carrier network. For any date of injury prior to the adoption of a network, an employee must select a treating physician within network subject to the statutory exceptions. A carrier must provide to the employees receiving treatment prior to adoption of the network all of the information that employers provide at the time of the adoption of the network. This eliminates the need to contact prior employers (some of whom may no longer be insured) to communicate the requirement to change to a network physician.

The section prescribes comprehensive requirements for notices of adoption of network to employers at the time of the adoption of the network, and notice given by carriers to employees treating for injuries prior to the adoption of the network.

Employers must adopt a "standardized process for delivering notice of network requirements,

including documentation of delivery of the notice and dates of delivery. The failure to do so creates a rebuttal presumption that the employee never received the notice.

Subchapter D: Network Requirements

10.61. Employees Who Live Within the Network Service Area, Employee Access and Insurance Carrier Liability for Health Care.
The section restates the statutory standard that employees may treat out of network because of an emergency or out of network referral approved by the network. The employee is presumed to live at the address communicated to the employer, or if no longer working for the employer, the address "on file with the insurance carrier." The rule permits employees to dispute and rebut the presumption.

For approval of referral doctors, the network should approve or deny within the time appropriate, but no later than seven days after the day of request for referral.

An employee living outside the network service area may treat within network by mutual agreement. An employee who misrepresents his or her living status in order to treat out of network may be liable for payment for that health care.

10.62. Dispute Resolution for Employee Requirements Related to In-Network Care.
Specifies the dispute process to be conducted by the insurance carrier, including a determination within seven days after receiving notice of the employee's request for review. The response must include a description of the evidence considered by the carrier when making the determination. A copy of the response must be provided to the employer.

Upon review, if the carrier determines the employee does not live within the service area, but does live within the service area of any other network established by carrier (called an "alternate network") carrier shall provide the employee with the opportunity to treat within that alternate network.

10.63. Plain Language Requirements.
Prescribes readability requirements so that it may be understood by a person with a ninth grade reading level. Contains other requirements for the form.

Subchapter E. Network Operations
10.80. Accessibility and Availability Requirements.
Specifies the following requirements:

(1) Adequate number of treating doctors and specialists available 24/7 within the

service area;
(2) Sufficient physicians to ensure choice, access and quality of care;
(3) Adequate number of doctors who have admitting privileges at network hospital;
(4) Hospitals must be available 24 hours a day, 7 days a week, including general, special, and psychiatric hospitals;
(5) PT/OT and chiropractic services;
(6) Emergency care 24/7;
(7) An adequate number of treating doctors qualified to perform MMI and IR services.

Appears to require that workers be seen within 21 calendar days of the date of request.

Networks must ensure that services are sufficiently accessible so that maximum travel distances required by employees treating in network are 30 miles in non-rural areas, 60 miles in rural areas, and 75 miles for specialists.

Requires an "access plan" to be approved for treatment outside the network service area and specifies requirements of the plan.

10.81. Quality Improvement Program.
Requires the network to develop and maintain continuous and comprehensive quality improvement program to evaluate and improve healthcare and specifies comprehensive requirements of the plans.

Networks will be required to have a medical case management program with certified case managers. It does not specify whether or not this function can be delegated to the carrier and whether or not carriers and networks may avoid an overlap between the independent requirements for each to provide case management.

10.82. Credentialing.
This very comprehensive rule prescribes the process for selection and retention of providers.

The network must document the process by a plan to include the following elements:
(A) Identify the doctor or healthcare practitioner responsible for the credentialing program and describe his/her participation.
(B) Written criteria for credentialing of provider, verification of credentials, verification of financial disclosure (provider's financial relationships with other providers).

Networks will not be required to credential hospital personnel, and other practitioners working

under the direction of a doctor, pharmacists or opticians.

Networks must monitor sanctions from Medicare, Medicaid, state licensing boards, complaints, and DWC.

The network procedures may not discriminate against providers who serve high risk populations or specialize in the treatment of costly conditions.

The network must notify DWC when a provider's affiliation is suspended or terminated due to quality of care concerns.

Prescribed provider application process and network verification requirements.

Subsection (A) (C) (iv) continues to require an onsite visit to the offices of each physician as a part of the initial credentialing process.

Recredentialing is required every three (3) years in order to update information obtained in the initial credentialing process.

10.83. Guidelines and Protocols.
Each network is required to adopt treatment guidelines, RTW guidelines, and individual treatment protocols following the statutory standards of evidence based, scientifically valid, outcome-focused, and designed to reduce inappropriate or unnecessary healthcare while safeguarding access to necessary care.

Treatment may not be denied solely because the guidelines do not address the treatment or injury (in that event, there should be a treatment protocol adopted by the network with respect to the specific service.)

Copies of all guidelines and protocols must be available to the providers.

10.84. Treating Doctor.
Refers to a doctor's statutory duties.

10.85. Selection of Treating Doctor; Change of Treating Doctor.
Restates statutory requirement, permitting specialists as treating doctors for chronic, life-threatening injury or chronic pain related to a compensable injuries. Provides for use of network specialists.
For HMO doctors, employee is a member of an HMO (not limited to employer's HMO) at the time of the employer's work-related injury, may request treatment by the HMO primary care

physician. The primary care physician must agree to comply with the network guidelines.

10.86. Telephone Access.
Networks are required to maintain specific telephone access logs for calls received outside of normal business hours.

Subchapter F: Utilization Review and Retrospective Review

10.100. Applicability.
Specifically adopts Insurance Code Article 21.58A regarding utilization review. In the event of a conflict, Chapter 1305 (HB 7) controls.

10.101. General Standards for Utilization Review and Retrospective Review.
Screening criteria must be consistent with network treatment guidelines, return to work guidelines, and individual treatment protocols. If a physician chooses to deviate from the treatment guidelines, screening criteria and individual treatment protocols, the physician must request approval from the network.

10.102. Notice of Certain Utilization Determinations; Preauthorization and Retrospective Review Requirements.
Labor Code and Rule 134.600 do not apply to in-network care. A preauthorization process within a network must comply with the utilization review requirements of Chapter 1305 (HB 7).

URA decisions must communicate reasons for adverse determination, clinical basis, screening criteria used in the determination, a validation that the provider making the determination is licensed in Texas, a description of the procedure for reconsideration, and a notification of the availability of independent review.

Preauthorization decisions must be determined within one hour of the request for post stabilization or life-threatening condition, within twenty-four hours of the request for a concurrent hospitalization, and for all other requests, the URA must "transmit the determination within three days."

10.103. Reconsideration of Adverse Determination.
Utilization review agents shall maintain and make available written descriptions of reconsideration processes. Reconsideration procedures must specify that:

(1) The reconsideration may not be performed by the same person;
(2) An employee may request reconsideration orally or in writing;
(3) Within 5 days of the receipt of the request, the person reconsidering the request must send to the requestor acknowledgment and a list of documents necessary;

(4) Decision on reconsideration must identify resolution, clinical reasons, clinical basis, and the specialty and states in which the provider is licensed and notice of the right to seek independent review. Reconsiderations must be determined and communicated within thirty days after receipt of the request.

Reconsiderations for treatment of post-stabilization and life-threatening conditions and concurrent hospitalization must be expedited and may not exceed one day from the date of receipt of all information necessary to complete the reconsideration.

Appeals from adverse determinations will be entitled to an “immediate review” by an IRO.

10.104. Independent Review of Adverse Determination.
The URA must forward the materials to the IRO within the third business day after notification of the assignment. The information must include the medical records, treatment guidelines, the notice of the determination and reconsideration, documents “in support of the request for reconsideration” (does not mention documents opposing the request for reconsideration nor mention the opportunity to supplement the documents with an analysis or any other statement of the carrier/networks decision), and a list of the providers providing care to the employee may have medical records relevant to the review.

A request for independent review must occur within the 45th day after the denial of the request for reconsideration. Insurance carriers must pay for the independent review, win or lose (this is a statutory requirement). The Department will assign the review request to an independent review organization – not the Commission. IRO decisions may be appealed to District Court.

Subchapter G. Complaints
10.120. Complaint System Requirement.
Prescribes complaint system.

10.121. Complaints; Deadlines for Response and Resolution.
Networks must acknowledge the complaint within seven days, investigate the complaint, and issue a resolution no later than thirty days after receipt. The network must maintain a complaint log, the requirements of which are specified in the rule.

10.122. Submitting Complaints to the Department.
Prescribes process for submitting complaints to TDI.

A person dissatisfied with the network's resolution of their complaint may submit a complaint to TDI. Prescribes process for submitting complaints to TDI.