SUBCHAPTER A. General Provisions and Definitions
§§10.1 - 10.2

SUBCHAPTER B. Certification
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SUBCHAPTER C. Contracting
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SUBCHAPTER D. Network Requirements
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SUBCHAPTER F. Utilization Review and Retrospective Review
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SUBCHAPTER G. Complaints
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1. INTRODUCTION. The Commissioner of Insurance adopts 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. Sections 10.1 - 10.2, 10.20 - 10.22, 10.24 - 10.27, 10.40 - 10.42, 10.60 - 10.63, 10.80 - 10.83, 10.85, 10.101 - 10.104, and 10.121 - 10.122 are adopted with changes to the proposed text as published in the September 2, 2005 issue of the *Texas Register* (30 TexReg 5287). Sections 10.23, 10.84, 10.86, 10.100 and 10.120 are adopted without changes.

2. REASONED JUSTIFICATION. 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 new sections will be applicable on January 1, 2006.

Pursuant to HB 7, the Texas Workers' Compensation Commission was abolished, and all functions of the Texas Workers' Compensation Commission were transferred to the newly created Division of Workers' Compensation at the Texas Department of Insurance (the department), effective September 1, 2005. Where appropriate for purposes of this order, references to the former Texas Workers' Compensation Commission shall be referred to as "the TWCC," and references to the Division of Workers' Compensation will be referred to as "the Division."

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 referenced 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.

Chapter 10 establishes standards and requirements applicable to networks, insurance carriers, other persons, and third parties operating under the Act. The 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 adopted sections 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.

This adoption 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.

Changes have been made to the proposed sections as published; however, none of the changes introduce new subject matter or affect additional persons other than those subject to the proposal as originally published. Throughout the adopted rule, the department has made editorial and grammatical changes for ease of reading and clarity and, where necessary, corrected punctuation, references and typographical errors.

The "Live" Issue. In developing these rules, the department considered the issue of what constitutes where an employee lives for the purpose of establishing the applicability of network requirements to a particular employee. Insurance Code §§1305.005(i) and 1305.007 give the commissioner rulemaking authority to implement Chapter 1305 to address this issue for employees who live outside network service areas. The department added language to the definition in proposed §10.2(a)(14)(A) that incorporates the presumption, found in the rule at §10.61(b), that the address the employee provides to the employer is where the employee lives. Using this address is the best available method for initially identifying where an employee lives and establishing a baseline that will be available to employers who are charged with delivering notices of network requirements that may be region-specific. There are circumstances that will require a more thorough analysis of where a particular employee

lives under the requirements of these rules, and the rules take these circumstances into account by retaining the flexibility provided in the proposed definition and by indicating that an employee may also establish that the employee temporarily lives in another location due to a work assignment or to receiving necessary assistance with the routine daily activities of living. Providing for a temporary change in where an employee lives is an important element of the definition due to the nature of some jobs that require frequent or lengthy temporary assignments away from an employee's principal legal residence. In such a circumstance, the employee should be able to receive necessary health care despite the employee's temporary location outside the network. Likewise, there are times when an injured employee may require assistance with routine daily activities and choose to receive this convalescent care from a family member that resides outside the network's service area. The employee will need the ability to receive health care services from providers near this temporary location, and the rule enables this by establishing the new location as the place where the employee lives during that time. Although some interested parties, as indicated in the comments, contend that these temporary locations are potential loopholes for fraudulent employees or providers, the absence of this allowance in the rule would operate as an unreasonable restriction on an employee's right to receive health care services for a compensable injury. Additionally, recognition of the temporary locations where an employee may live allows the employee to receive necessary care while away from the legal residence, thus furthering the goal to return the employee to work efficiently and expediently. Conversely, a delay in care while an employee is away from the

employee's legal residence may delay an injured employee's return to work. Furthermore, unnecessary delay of care punishes an employee who is attempting to return to a job that requires temporary assignments to new locations and an employee who is attempting to recover from an injury in order to return to work. By including a mechanism through which a carrier may contest an employee's assertion that the employee lives outside the network, the adopted rule strikes a balance between avoiding potential fraud and delivering necessary care to an employee who is forced to temporarily relocate. A carrier may also establish multiple service areas or contract with multiple networks in such a way that much of the state is covered by an applicable network service area. This will allow carriers and employers to make use of the network model for more employees and in more circumstances so long as the employees are given appropriate notice of the applicable network.

Treatment Guidelines. The department has changed the rule in §§10.42(b) and 10.101(b) to require networks and carriers to be flexible enough to allow deviations from network treatment guidelines. New §10.42(b)(3) requires provider contracts to include a statement that the insurance carrier or network may not deny treatment solely on the bases that a treatment for a compensable injury in question is not specifically addressed by the treatment guidelines used by the insurance carrier or network. Section 10.101(b) was changed to reference a carrier's retrospective review program in addition to a carrier's utilization review program such that a carrier may choose to use a pre-service or post-service process for a treating doctor or specialist to request approval from the network for deviation from treatment guidelines, return-to-work guidelines and individual

treatment protocols where required by the particular circumstances of an employee's injury. The department acknowledges that a deviation procedure is necessary, and the change to the language allows networks the flexibility to design their own procedures. The statute, at Insurance Code §1305.304, requires networks to adopt treatment guidelines. Insurance Code §1305.152(c)(2) requires that the guidelines be made applicable to providers through the network-provider contract. The statute does not address deviations from treatment guidelines, but the commissioner may specifically address the issue through the rulemaking and implementation authority provided at Insurance Code §1305.007. In doing so, the department considered that the statute prohibits a carrier from denying payment for a particular treatment solely on the basis that the treatment for the compensable injury in question is not specifically addressed by the treatment guidelines used by the insurance carrier or the network. The department also considered that carriers are given latitude as to the use of preauthorization requirements and that requiring pre-service approval of deviations could impact the basic model of a network that declines to make extensive use of preauthorization requirements. As a result, carriers and networks can design their procedures such that the carrier may engage in retrospective review of the deviation, but any objection to the deviation must be based on something more than the fact that the treatment was not addressed in the treatment guideline. The department anticipates that this will most likely take the form of a denial based on the medical necessity of the services. The department has therefore made the deviation process a part of the utilization and retrospective review procedures. In evaluating a request for

deviation, carriers cannot rely strictly on any applicable screening criteria, as screening criteria will necessarily be consistent with the treatment guidelines from which the provision is requesting deviation.

Notice of Network Requirements. In proposed §10.60(a), (a)(1), (a)(2), and proposed §10.61(f)(4), in response to comments and for clarification, the department has deleted specific references to subsections (d), (e) and (g) of Insurance Code §1305.005. These changes clarify that every employee should receive an initial notice of network requirements and a notice at the time of injury. It is not sufficient for an employer to provide an employee with only the initial notice, even if the employer obtains a signed acknowledgement from the employee at that time. This requirement is consistent with the statutory requirements and gives an injured employee the best opportunity to be fully aware of the network requirements and the most current information regarding network configuration and available providers. A notice is not effective unless it is accurate, appropriate and sufficient to alert an employee to the existence of a network or network service area in which the employee lives. Thus, there is a two-prong test for determining whether an employee will be required to receive care pursuant to a carrier's network requirements. Under the test, an employee must live within a service area and must receive notice of network requirements that is applicable to the employee's location. The department received numerous comments regarding the potential for a carrier's use of multiple networks encompassing several different service areas and regions. Other commenters were concerned that large networks with multiple service areas would be forced to provide voluminous notices that applied to the entire state

despite the practical reality that the coverage was issued to a regionally specific employer. Under the rules, a notice of network requirements may be limited to a specific region. Additionally, the department understands that insurance carriers and employers are given the flexibility to contract for very limited or expansive networks that may be offered by or through a carrier. However, carriers and employers should be aware that employees will be required to comply with only those network requirements of which they have received notice. For those employees who live outside the service area or areas described in the notice, the network requirements will not apply. This is true without regard for whether there is an alternate service area or network, unless the notice of that service area or network is subsequently delivered to the employee. For employees who are frequently away from the employer's regional area due to temporary work assignments, the best way for an employer or carrier to take advantage of large or statewide networks with multiple service areas is to provide notice of any and all applicable service areas. Although the rule does allow a carrier to provide notice of an alternate service area during the process of determining whether an employee lives outside a service area, the notice of the alternate service area is subject to the same basic principle that network requirements are not applicable until the employee has received an appropriate notice. This approach allows carriers and employers to be aware of which requirements apply to employees. Similarly, it provides an assurance that employees will not be held liable for out-of-network services received by an employee who had no knowledge of the network requirements.

Use of Electronic Means. The adopted rule includes changes to proposed §10.60(f) to clarify that electronic signatures are acceptable and acknowledgment of notice requirements may be accepted by electronic means. This should allow employers and carriers to take advantage of the ease and expediency afforded by allowing their employees to provide a signature by electronic means. Additionally, the adopted rule also includes changes to §10.60(c) to provide that employers and carriers may issue electronic notices of network requirements, including provider directories, provided that paper copies are available upon request.

Sample Acknowledgment Form. The rules include reference to a sample acknowledgment form that carriers and employers may obtain from the department's website. The sample is not mandatory, but is provided as an effort by the department to better facilitate an employer's efforts to comply with the rule. Carriers and employers may use the sample form, modify the sample form appropriately to suit their needs, or use another employee acknowledgment form that complies with the requirements contained in §10.60(d)(2).

Subchapter A. The department has added a severability clause as new subsection (e) to proposed §10.1, which provides that if a court of competent jurisdiction holds that any provision of this chapter is inconsistent with any statutes of this state, is unconstitutional, or is invalid for any reason, the remaining provisions of Chapter 10 shall remain in full effect. This provision is necessary to clearly state the department's intent. The department has clarified in proposed §10.2(a)(18) that an organization that is formed to arrange for health care services to injured employees is a workers'

compensation health care network if it meets the remaining elements set forth in the definition. This clarification is consistent with Insurance Code §1305.101, which provides that "...a network shall provide or arrange for health care services...."

Subchapter B. In response to a comment, the department has deleted proposed §10.20(b) as unnecessary. Accordingly, numbering changes have been made within §10.20. The department has also changed proposed §10.20(a)(2) (§10.20(2) as adopted) in response to a comment to clarify that the section applies only to those entities that provide workers' compensation health care network services. In proposed §10.21(c), the department corrected the HMO Division mailing address. In response to comments that the proposed financial reporting requirements for networks are overly burdensome, the department deleted the requirement in §10.22(7) that networks provide a statement of equity to reduce the burden of providing detailed financial information for non risk-bearing entities. The department notes, however, that the commissioner retains the authority under the Insurance Code to request such information. In proposed §10.22(13) the department deleted the requirement that network applications include pro forma financial projections and substituted a requirement that networks provide projections for anticipated revenue and profitability for the first two years of operation after certification. In response to comments, the department added to proposed §10.22(14) an exemption from the requirement that network applications include a financial authorization form to lessen the burden for applicants who are licensed, risk-bearing entities because these entities' assets have already been subject to department examination. In proposed §10.22(17), in response

to comments, the department has modified the language to require that applicants submit a plan for obtaining certification of provider filings of financial disclosure with the Division. In proposed §10.24(b)(2), the department added the HMO division mailing address for providing the network's financial statement. In proposed §10.25(b)(3) (§10.25(a)(3) as adopted), the department added the phrase “material modification" before "network configuration” to clarify that networks need prior approval of material changes to network configuration. In accord with the change to the language in proposed §10.22(13), the department changed §10.26(b)(3) to correct a reference from §10.22(7) to §10.22(13), deleted the reference to “pro forma financial statements,” and added the word "projections." In proposed §§10.25, 10.26, and 10.27, the department added language in response to comments to clarify that networks do not need to file an entire application each time they report information that amends their initial network application. In proposed §10.25(a) (§10.25(b) as adopted), the department revised the language to state that a network shall file any information other than the information in subsection (a) of this section that amends, supplements, or replaces the items required under §10.22 of this chapter, which information must be filed no later than 30 days after implementation of any change. In proposed §10.26(g)(2) and §10.27(f)(2), the department corrected the HMO Division mailing address. The department changed the language of proposed §10.27(f) to clarify that all network modification request forms, and not only those which relate to network configuration, may be obtained from the same location.

Subchapter C. In §10.40(a) as proposed, the department corrected an incorrect reference in the rule to more accurately reflect the requirement under Insurance Code §1305.102 by changing "in accordance with this chapter" to "by the commissioner in accordance with Insurance Code §1305.102." The department added “as applicable” at the end of proposed §10.41(a)(9) in response to comments to clarify that not all networks will have the delegated responsibility for payment to providers or notification to employees. In proposed §10.41(a)(15)(B), the department added language in response to comment to clarify that complaint logs and complaint files are required to be disclosed to the extent permitted by law. This clarification takes into account that privacy, confidentiality, or security law or other applicable law may prohibit release of certain portions of a complaint log or complaint file. The department changed the language of proposed §10.42(b)(1) in response to comment to clarify that the provision requiring provider contracts and subcontracts to include a hold-harmless clause stating that the provider and provider network will not bill or attempt to collect payment for health care services for compensable injuries from the employee may not apply in some situations as set forth in Insurance Code §1305.451(b)(6). In proposed §10.42(b)(4)(B) (§10.42(b)(5)(B) as adopted), the department changed the "dispute resolution process" to the "complaint resolution process" to accord with the statute. In response to comment, the department has deleted the requirement in proposed §10.42(b)(6)(B) that members of a network’s advisory review panel must be network providers and added the requirement that the members be of the same licensure as the provider appealing a termination. In §10.42(b)(6)(G) as proposed, the department has added the words “a

provision that" to clarify that network contracts with providers must contain provider termination provisions. The department has restructured provisions of proposed §10.42 and has renumbered remaining provisions accordingly. The department has added new §10.42(b)(14) in response to comment to require that network contracts with providers contain a statement that the provider specifically agrees to provide treatment for injured workers who obtain workers' compensation health care services through the network that is specifically identified in the contract as a contracting party. In proposed §10.42(d), in response to comments, the department removed "any" before "economic problems" to clarify the carrier and network are not required to provide notice each time a utilization management study is performed.

Subchapter D. In §10.60(b), the department made a change to reflect that a carrier must comply with §10.60(c) - (h) when a carrier has an obligation to deliver the notice of network requirements and obtain the signed acknowledgment form. In proposed §10.60(c), the department made grammatical changes relating to the phrase "must be in" for clarification. The rules include reference to a sample acknowledgment form that carriers and employers may obtain from the department's website. Carriers and employers may use the sample form references in §10.60(d)(2), modify the sample form appropriately to suit their needs, or use an employee acknowledgment form that complies with the requirements contained in §10.60(d)(2). In proposed §10.60(d)(2), the department changed the HMO Division mailing address. In proposed §10.60(e)(2)(C), the department added "other than emergency care" to clarify that if the employee seeks health care other than emergency care from someone other than a

network provider without network approval, the insurance carrier may or not be liable, and the employee may be liable for payment for that health care. This change is in accord with Insurance Code §1305.006. In proposed §10.60(e)(3), the department changed "living address" to "where the employees" for clarification. In response to a comment, the department clarified in proposed §10.60(f) that a carrier required to provide employee information to an employee under Insurance Code §1305.103(c) and §10.60(b) shall obtain a signed employee acknowledgment form from that employee. In response to comments, the department added language in proposed §10.60(g)(5) to clarify that if it is ultimately determined that the employee lives in the network's service area, there may be some situations in which the carrier is not liable and the employee is liable for the payment of health care services. In response to comments that 21 days is too long for certain injured employees to wait for a referral to a specialist, the department has added language in proposed §10.60(g)(15) to clarify that a network must arrange referrals to specialists within the time appropriate to the circumstances and condition of the injured employee but not later than 21 days after the date of the request. In proposed §10.60(h), the department has added language in response to comment to require that an employer or carrier delivering the notice of network requirements and employee acknowledgment form to employees document the location of the delivery in addition to the delivery method, to whom the notice was delivered, and the delivery date(s). The department also added language to clarify that an employer's or carrier's failure to incorporate mandatory documentation elements into a standardized process for delivering the employee notice of network requirements creates a rebuttable

presumption that the employee has not received the notice and is not subject to network requirements. In proposed §10.61(d) and proposed §10.62(e), the department substituted the word “a” for “the” before “network” for clarification and for consistency with the language in Insurance Code §1305.301(d), which refers to networks establishing one or more service areas within the state. In response to comments, in proposed §10.61(e), the department substituted the word “intentional” for the word “material” before the word “misrepresentation” to clarify that only intentional misrepresentations regarding where the employee lives are at issue in this provision. This change prevents an employee who may make unintentional misrepresentations regarding where the employee lives from being unduly punished for the mistake. In proposed §10.61(f)(4), the department has added the words “and service area” after “the appropriate network,” for clarification. In §10.63(b) as proposed, the department has added language in response to comments to clarify that the network certification required in connection with the notice of network requirements and employee information forms under proposed §10.63(b) must be filed with the department only and need not be distributed to every employee enrolled in the network plan.

Subchapter E. In proposed §10.80(b)(7), the department deleted the word "treating" before "doctors" for clarification and in response to commenters who urged that doctors other than treating doctors may assess maximum medical improvement and impairment rating services. In proposed §10.80(h), the department has changed "a skill or specialty" to "skilled or specialty care" for clarification. In response to comment, the department changed the language of proposed §10.81(b)(2)(B)(vii) to "provider billing

and provider payment processes, if applicable" to require the annual quality improvement work plan to include both the provider billing and provider payment processes. In proposed §10.81(c)(1), the department deleted the language “or any other national accreditation entity recognized by rules adopted by the commissioner of insurance” because the department has not recognized any other national accreditation entity recognized by rules adopted by the commissioner. In proposed §10.81(g), the department added language in response to comment to allow for a temporary phase-in of case management certification requirements. The department modified requirements set forth in proposed §10.82(a)(1)(B) in response to comments that the requirement for a network to verify the status of financial disclosure filings for each provider in the network is overly burdensome and costly. In §10.82(a)(1)(B), the department deleted the requirement that networks develop written procedures for verifying that the provider filed financial disclosure information with the Division and added language that provides that written procedures for verifications shall instead include certification by applicants of completion of required maximum medical improvement and impairment rating training and filing financial disclosure. Further, in §10.82(a)(1)(B) as proposed, the department added language requiring networks to make available to network providers or applicants, upon request, all credentialing criteria and procedures. In proposed §10.82(a)(1)(B)(viii), in response to comments, the department deleted unnecessary language. In proposed §10.82(a)(1)(C), the department has added new clause (vi), which contains language allowing networks to phase in required site visits to treating doctors until not later than the first anniversary after the date of the network's

certification and details certain other requirements. Additionally, the new clause provides that if the department receives a complaint about a treating doctor who has not had a site visit, the network is to perform the site visit not later than 30 days after notification by the department of the complaint, unless circumstances warrant an immediate site visit, and shall take action to correct any deficiencies found. In §10.82(a)(1)(E)(iv), (a)(1)(E)(v) and (a)(1)(F) as proposed, the department deleted references to institutional providers and substituted the words "health care facilities" for clarification and consistency with other language in the rule. In proposed §10.81(a)(2)(E)(iii), the department added “compliance with” before “other applicable state or federal requirements” to clarify the contents of the credentialing process for health care facilities and changed Texas Department of Mental Health and Mental Retardation to the Texas Department of State Health Services to reflect an organizational change. In proposed §10.82(d)(2), the department deleted two references to "NCQA" and added the phrase "one of the national accreditation organizations as described in §10.81(c) of this subchapter (relating to Quality Improvement Program." for clarification that entities may be accredited by national accreditation organizations other than the NCQA in accordance with §10.81(c). In proposed §10.83(c), the department substituted the word “accessible” for “available” to emphasize that networks are to allow providers ready access to treatment guidelines. In response to comments, the department corrected a minor grammatical error in proposed §10.85(d) by changing “a” to “an” before the word "employee’s." In proposed §10.85(d), the department revised the language specifying how an employee who is a

member of an HMO at the time of the employee's injury may request that the employee's HMO primary care physician or provider also serve as his treating physician under Insurance Code Chapter 843, as the terms "physician" and "provider" are defined in that chapter. Additionally, the department has added “as applicable to treating doctors” in the last sentence to clarify that treating doctors need only abide by the rules that apply to them.

Subchapter F. In response to comments, the department modified proposed §10.101(b) to require that the carrier's utilization review program and retrospective review program include a process for a treating doctor specialist to request approval from the network for deviation from the treatment guidelines, return-to-work guidelines, and individual treatment protocols where required by the particular circumstances of an employee's injury.

In response to comment, in proposed §10.102(c)(4), the department deleted "and a validation that the provider is licensed in accordance with Labor Code §408.0231(b)" because the department does not have authority to require Texas licensure for providers involved in utilization review. In response to comment, in proposed §10.102(g), the department deleted two references to "retrospective review" because the language addressing the timeline requirements for retrospective review are addressed in new §10.102(h). In new §10.102(h) and in response to comments, the department added language related to adverse determinations made pursuant to retrospective review which requires the adverse determination to be issued in response to a claim for payment consistent with the timelines set forth in Labor Code §408.027

related to payment of health care to providers. In proposed §10.103(a)(4)(B)(iv), the department corrected a reference by deleting a reference to §10.102(h) and adding a reference to §10.102(i). The department deleted proposed §10.104(i) which provided that judicial review shall be conducted in the manner provided for judicial review of contested cases under the Government Code because this requirement is not in Insurance Code Chapter 1305.

Subchapter G. In proposed §10.121(c), in response to comments requesting clarification concerning whether the term "days" in Subchapter G means business days or calendar days, the department has added the word “calendar.” In proposed §10.122(b)(2), the department corrected the HMO Division mailing address.

Fees and Documentation. The provisions of Insurance Code Chapter 1305 clearly allow the networks to contractually negotiate fee reimbursement and do not adopt the Division of Workers’ Compensation fee guidelines. Likewise, any documentation requirements dictated by the Division of Workers’ Compensation fee guidelines do not apply to networks. The department encourages networks, carriers, and providers to address any documentation requirements during the contract negotiation process. These discussions provide an excellent opportunity to ensure claims management needs are met, while decreasing the likelihood of administrative hassles associated with document submission.

Division Responsibilities Within the Department. With the implementation of the network infrastructure, it is necessary that different divisions within the department, depending on the specific subject matter, handle the various operational responsibilities.

For example, the department's HMO Division will handle complaints related to provider adequacy issues within a network, but disputes regarding the entitlement to travel reimbursement associated with securing healthcare within a network will be handled by the Division of Workers' Compensation. The source of the statutory authority is a simple indicator of the responsible division (Insurance Code provisions are generally handled by the HMO Division and Labor Code provisions are generally handled by the Division of Workers' Compensation). All divisions within the department will be working closely together to minimize any potential problems created by this regulatory scheme, including, where appropriate, revising existing processes, organizational responsibilities, and rules.

3. HOW THE SECTIONS WILL FUNCTION. Subchapter A contains general provisions and definitions regarding this chapter. Section 10.1 explains the purpose and scope of this chapter. Section 10.2 defines certain terms used in this chapter.

Subchapter B describes the process for the certification of workers' compensation health care networks. Section 10.20 provides that certification under Insurance Code Chapter 1305 and the other provisions of Chapter 10, except under certain circumstances, is a requirement for operating a workers' compensation health care network. Section 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. Section 10.22 lists the requirements for the contents

of the certificate application. Section 10.23 provides that the commissioner will approve or disapprove an application for certification of a network in accordance with Insurance Code §1305.054. Section 10.24 lists the financial information that certified networks must provide to the department and carriers with which the network contracts. Section 10.25 lists the filing requirements for networks after issuance of the network's certification and requires that the network file with the department a written request for approval before making certain changes. Section 10.26 sets forth the requirements for modification to a network's service area and specifies the associated information a network must provide to the department for prior approval when it modifies a service area. Section 10.27 provides the requirements for modification to a network's configuration, including filing a modification request with the department for prior approval.

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

Subchapter D details various network requirements. Section 10.60 specifies notice of network requirements and employee information, which include both the notice of network requirements, 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. Section 10.61 specifies 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. Section 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. Section 10.63 specifies the plain language and other requirements for the notice of network requirements, employee information, and employee acknowledgment form.

Subchapter E lists network responsibilities related to network operations. Section 10.80 outlines the accessibility and availability requirements for networks and network providers. Section 10.81 describes the mandated quality improvement program for monitoring and evaluating the quality and appropriateness of health care and network services. Section 10.82 outlines the credentialing process required for network doctors and health care practitioners. Section 10.83 addresses treatment guidelines, return-to-work guidelines, and individual treatment protocols for network care. Section 10.84 specifies compliance requirements for treating doctors. Section 10.85 provides for an employee's selection and change of a treating doctor. Section 10.86 specifies the criteria for a network's required establishment and maintenance of telephone access logs.

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. Section 10.100 applies Insurance Code Article 21.58A to utilization review conducted in relation to claims in a workers' compensation network and, provides that in the event of a conflict, the requirements of

the Act apply. Section 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. Section 10.102 establishes notice requirements for persons performing utilization review or retrospective review for an injured employee receiving health care services in the network. Section 10.103 sets forth standards for reconsideration of adverse determinations, including requirements for maintaining and making available a written description of the reconsideration procedures involving an adverse determination. This section also requires that the reconsideration procedures be reasonable and contain certain provisions. Section 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 that the insurance carrier shall pay for the independent review provided under this subchapter.

Subchapter G describes requirements relating to complaints. Section 10.120 requires each network to implement and maintain a complaint system that provides reasonable procedures for resolving oral or written complaints. Section 10.121 establishes requirements for complaints and deadlines for responses and resolutions.

Section 10.122 provides for filing complaints with the department. Persons who are dissatisfied with the resolution of complaints by the network may file a complaint with the department on forms that may be obtained from the department's website of from the HMO Division.

4. SUMMARY OF COMMENTS AND AGENCY'S RESPONSE TO COMMENTS.

General: A commenter notes that network mandates should be subject to careful cost-benefit analysis so that any mandates do not compromise the ability of networks to deliver cost-effective, high quality care.

Agency Response: The department generally agrees with the commenter’s concern.

General: A commenter requests additional language in the rule relating to the value that third party processors can bring to the system that would specifically allow employers and health care providers to contractually assign or outsource claims processing, billing, collections, or fulfillment of benefits or services deemed medically necessary and appropriate and delivered through workers’ compensation networks.

Agency Response: The department declines to change the rule. Except for certified self-insured employers who are “insurance carriers,” Chapter 1305 and the rules do not address an employer’s authority to delegate or outsource functions. With regard to providers, Insurance Code §1305.152(c) and §10.42(b) allow for network contracts with providers to include subcontracts which meet the requirements of the statute and rule. The department sees no need to adopt additional language that would specifically allow

health care providers to contractually assign or outsource “fulfillment of benefits or services deemed medically necessary and appropriate and delivered through workers’ compensation networks.” Except for the amount of reimbursement determined by the contract between the network and providers, billing by and reimbursement to providers is subject to the requirements of the Texas Workers’ Compensation Act as set forth in Insurance Code §1305.153(d). Labor Code §413.011(a) and §413.053 authorize the commissioner of the Workers’ Compensation Division to adopt rules relating to billing and health care reimbursement.

General: A commenter is concerned with the complexity of TWCC's forms and suggests, that to reduce the cost of workers' compensation coverage, the state should simplify the paperwork, hold both payer and providers to the contracts, and penalize the outliers. The commenter states that payer plans often delay, deny or mispay claims. Currently, if a physician remains out of network, he can receive 125% of Medicare. If providers are paid within 30 days of receipt of a clean claim, then 115% of Medicare would be a reasonable reimbursement.

Agency Response: The department appreciates the comment. Future rulemaking by the Division may address the administrative issues identified by the commenter and will be a more appropriate forum for these concerns.

General: A commenter is concerned about what providers the networks are going to try to exclude and why, and suggests that there should be an equal playing field for participants who are qualified and willing to play by the rules.

Agency Response: The department notes that, under Insurance Code §1305.152(b), a network is not required to accept an application for participation in the network from a health care provider who otherwise meets the requirements specified in Chapter 1305 for participation if the network determines that the network has contracted with a sufficient number of qualified health care providers.

General: A commenter questions who is going to make the determination of adequate care.

Agency Response: Insurance Code Chapter 1305 includes checks and balances for the determination of adequacy of care. The network initially determines adequacy of care because the network is responsible for contracting with providers for the provision of health care and performing functions related to the operation of a quality improvement program and credentialing in accordance with applicable statutes and rules. If the department determines that the network does not meet the adequacy of care requirements of the statute, the department will take appropriate action, including disciplinary action against the carrier, the network or both.

General: A commenter appreciates the hard and good work done by the department regarding HB 7.

Agency Response: The department appreciates the comment.

General: A commenter handles claims on behalf of insolvent property casualty carriers, including workers' compensation carriers, and suggests inserting an insolvency clause regarding what happens in the event that the carrier becomes insolvent and the carrier is utilizing a network.

Agency Response: HB 7 and these rules do not directly address the insolvency of an insurance carrier. Adding this subject matter to the rule would be a substantive change and would not allow all interested stakeholders to comment on the change.

General: A commenter thinks the proposed rule is very good and is very excited about it. The commenter notes that case management and utilization review are important components of any certified network program and need to be integrated within the network; that providers that have the right outcomes and the right focus need to be identified, and that networks that file for certification need to have the right mix of physicians.

Agency Response: The department appreciates the comment.

General: A commenter requests that the department add outpatient therapy centers at page 12, line 22.

Agency Response: The department is unable to locate the specific provision which the commenter references using the page and line numbers provided in the comment.

The department has searched various versions of the proposed rule, including the informal draft, the Texas Register proposal, and the electronic document on the department's web site.

General: A commenter has concerns about how providers are going to know when a patient schedules an appointment or comes into their office if the $7,000 threshold regarding carrier liability for health care provided has already been met. The commenter requests that the workers' compensation system include some type of documentation to determine if the $7,000 threshold has already been met.

Agency Response: The proposed rule does not address this issue. The department believes that any change to the rule in response to these comments would be a substantive change to the rule and would not allow all interested stakeholders to comment. The department notes that once a network provider receives notification under Insurance Code §1305.153(e) that a carrier is contesting compensability, the provider may contact the carrier to see if the $7,000 has already been met.

General: A commenter is concerned about the effect that the effective date of the rules will have on employers no longer in business, but with whom a carrier still has a bona fide active claim, or employers who have changed carriers and are using a different network than the carrier is using and leaving the carrier stuck with that claim as an active claim. Another commenter states that there should be some protection for the

networks if they have set up treatment protocols and a program on how to deal with old claims so that there is no increase in litigation.

Agency Response: Section 10.60(b) provides that an injured worker will receive a notice of network requirements from a carrier that is responsible for a particular injured worker's claims. This will not have an effect on an employer, as coverage for the injury is the responsibility of the carrier. Existing claims from an injured worker may not be appropriate for a network's treatment guidelines, as the guidelines do not apply retroactively. New claims that are the result of an existing injury will be subject to network treatment guidelines, but may be appropriate for a deviation from the guidelines if the established course of treatment is inconsistent with the network's guidelines.

General: A commenter requests clarification on whether required medical examiners can participate in the network. It is the commenter's understanding that with the elimination of the designated doctors' list, medical disputes are referred back into the network to be evaluated by a network provider other than a designated provider or treating doctor. The commenter understands that additional rules will be forthcoming but desires initial clarification to ensure proper development of the network.

Agency Response: Labor Code §408.004(f), as amended by HB 7, specifically excludes the use of Required Medical Examinations (RMEs) to determine the appropriateness of health care provided through a workers' compensation health care network established by Chapter 1305, Insurance Code. HB 7 did not eliminate the designated doctors' list, but rather added new issues to the list of issues the designated

doctor may address under Labor Code §408.0041 (including issues related to an injured employee's ability to return to work, the extent of the employee's compensable injury, and whether the injured employee's disability is a direct result of the work-related injury). Additionally, HB 7 allows the use of designated doctors to resolve disputes regarding the issues listed in Labor Code §408.0041 for network claims. However, Insurance Code §1305.101(b) does prohibit a network doctor from serving as an RME or designated doctor for an injured employee who is being treated by the same network in which the doctor also participates. Additionally, regardless of whether an injured employee is receiving medical care by a network certified under Chapter 1305, medical disputes related to prospective and retrospective medical necessity denials will be handled by independent review organizations (IROs) licensed by TDI.

Transition: A commenter has various concerns about the overall transition to the network, including the waiting period from the time that the network is approved until the time the actual network goes into effect, and wants to know who is going to notify the employees about the transition and explain issues including the provision being made for continuity of care. Another commenter suggests the department's educational outreach might include: (1) some language in the proposed rules; (2) education of the division by different stakeholders; (3) a commissioner's bulletin, and (4) Fastfax.

Agency Response: The department plans to address the commenters' concerns through an upcoming education program and other means such as FAQs, as one commenter suggests.

Electronic Submission and Processing of Claims: A commenter participates with a number of organizations in electronic processing of claims and bills and would be happy to help share some of that information. Another commenter supports electronic claims in Texas workers' compensation as a huge cost saver to the system. Another commenter supports electronic means of credentialing rather than paperwork. One commenter states that paperwork and forms and lack of electronic claims are a problem. The commenters note that for HMOs and PPOs it is very important that providers submit claims and any additional documentation such as forms electronically because it saves so much money in the system. The commenter encourages the exploration of current capabilities that exist in the TxComp system and how the providers, carriers and other stakeholders can access the TxComp system.

Agency Response: The department appreciates the comment. HB 7 §8.008 requires the commissioner of workers' compensation to adopt rules regarding electronic billing requirements under Labor Code §408.0251. The department will share these comments, including the comment regarding the TxComp system, with the Division, which administers the TxComp system.

Prompt Pay and Fraudulent Claims: A commenter requests that in cases of fraud with multiple red flags, carriers need an exception from the prompt pay rules. The commenter adds that prompt pay deadlines may impede a fraud investigation because

sometimes it takes longer than the prompt pay rules allow to investigate a claim in order to actually complete and investigation and prove fraud.

Agency Response: The commenter's request is outside the scope of the Chapter 10 rules. Insurance Code §1305.106 states that Labor Code §408.027 applies to a carrier's payment, reduction, denial, or determination to audit a claim for services provided through a workers' compensation health care network. Labor Code §408.027(g) authorizes the commissioner of workers' compensation to adopt rules as necessary to implement Labor Code §§408.027 and 408.0271.

Fraud: A commenter is concerned about fraud in the context of designated doctor issues and thinks that there should be some criteria so that injured workers cannot just say they are unhappy with the treatment plan the network has given them and just go to a designated doctor.

Agency Response: The Labor Code, at §408.0041, gives injured workers the opportunity to seek an opinion from a designated doctor for certain issues. The department declines at this time to place limits on this allowance in the statute, but will monitor this issue in the context of concerns regarding fraud.

§10.1: The commenter recommends the adoption of language to more clearly define a pharmacy's role within the Act. The commenter believes that any properly licensed pharmacy that wants to participate in the network should be permitted to do so and that there should be no restrictions on an injured employee's ability to select a pharmacy.

The commenter requests the addition of language specifically setting forth this ability. Another commenter recommends the addition of language to clarify that pharmacy and pharmacy services may not be delivered through a workers' compensation network to preserve choice among pharmacy providers by injured workers.

Agency Response: The department declines to make the requested changes. Insurance Code §1305.101(c) states that prescription medication or services may not be provided via a workers' compensation network. Prescription medication and services shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation.

§10.2: The commenter proposes adding the Labor Code definition for "health care reasonably required" to the list of definitions adopted from Labor Code §401.011 for later use in Subchapter F (related to utilization review and retrospective review) of these rules.

Agency Response: The department declines to make the requested change. The term "utilization review," as used in the statute, has the meaning assigned by Insurance Code Article 21.58A. The term is defined in Article 21.58A by using "medical necessity" rather than the commenter's suggested language.

§10.2: A commenter asks whether the rule excludes non-risk assuming preferred provider organization (PPO) networks from those entities that are able to operate as a certified workers' compensation health care network. If so, the commenter requests

that the department provide a definition that distinguishes between a PPO plan and a PPO network. Another commenter recommends that health care providers should be allowed to form workers' compensation networks in Texas as they are allowed to do so in managed care and in other states and therefore requests the specific addition of "groups of health care providers" as a new subsection (5) to §10.1(a).

Agency Response: The language of §10.20(a)(2) (§10.20(2) as adopted), combined with the definition of "person" in §10.2, allows a non-risk assuming PPO network to be certified and operate as a workers' compensation health care network. Any person, including a PPO network formed by providers or another entity, that is performing the acts described in §10.20(a)(2) (§10.20(2) as adopted) is required to obtain certification from the department. As a result, the requested definitions of "groups of health care providers," PPO plans and PPO networks are unnecessary.

§10.2: A commenter requests that the department create a special term and definition for the four types of entities that can contract with or establish networks for use throughout Chapter 10 wherever applicable when the term "insurance carrier" or "carrier" is used. The commenter then recommends modifying §10.2(18)(C) by deleting the reference to an insurance carrier and inserting the defined term for the four entities.

Agency Response: The department declines to make the requested change. "Insurance carrier" is defined in §10.2(b)(12) by reference to Labor Code §401.011(27). Labor Code §401.011(27) defines "insurance carrier" as: (A) an insurance company; (B) a certified self-insurer for workers' compensation insurance; (C) a certified self-

insurance group under Chapter 407A; or (D) a governmental entity that self-insures, either individually or collectively. Therefore, the references to “insurance carrier” or “carrier” throughout the rule include those four types of entities that can contract with or establish networks.

§10.2: A commenter requests that the department define medical necessity according to the American Medical Association guidelines.

Agency Response: The department declines to revise the proposed rule to incorporate the requested change. Such revisions would substantively change the rule late in the rulemaking process, which would circumvent the protections afforded by Government Code §2001.029 and require republication of the rule with another 30-day comment period before the rule could be considered for adoption. The department will monitor to determine if future revisions to the rule are necessary.

§10.2(a): The commenter recommends deleting the phrase "unless the context clearly indicates otherwise" from the first sentence in §10.2(a) because it allows for the selective use or interpretation of each definition.

Agency Response: The language is statutory and allows for sufficient flexibility where required while still setting forth a specific meaning for each defined term. The department declines to make the change.

§10.2(a): Commenters requested that the department define the terms “medically necessary” and “medical necessity” in order to avoid confusion regarding the interplay between appropriate, necessary or reasonably required services. Other commenters state that there will be no consistency in determinations because the definitions of “adverse determination,” “fee dispute” and “independent review” reference “medically necessary or appropriate,” without providing a specific definition of the phrase “medically necessary or appropriate.” Another commenter requests that the entities that make the determination be specifically identified in the rule because without definition it is unclear whether the health care providers decide which injuries should and should not be treated and to what extent; or, should a reviewer make that decision post-injury having never seen the patient and not knowing how complete the documents or file provided may be?

Agency Response: The department declines to add a definition for these terms without first affording all interested parties an opportunity for comment. As to the concern regarding the entities that make particular determinations referenced by the commenter, the rule and the statute identify the appropriate entities without the need for additional definitions. The available levels of review of the determination that are available are likewise identified in the rule. In general terms, both the statute and the rule reference Insurance Code Article 21.58A, which provides that a carrier or licensed utilization review agent is charged with determinations of medical necessity and issuing adverse determinations.

§10.2(a): Commenters recommend the addition of language to define "medical treatment guidelines," "nationally recognized," "outcome focused," and "scientifically valid."

Agency Response: The department believes that the terms are generally understood and do not require definition. The department declines to make the suggested change.

§10.2(a): A commenter states that the definition of "adverse determination" is inconsistent with the definition contained within Insurance Code §843.002(1) and should be made consistent with the HMO Act. The commenter believes that the provisions in the HMO Act and the Texas Workers' Compensation Act should be consistent to the extent possible so that the workers' compensation system will mirror the commercial products in the market.

Agency Response: Section 10.2(a)(1) reflects the language of the statute at Insurance Code §1305.004(a)(1). The department declines to make the change.

§10.2(a)(4): A commenter recommends adding language that specifically references allowing a person's agent or assignee to qualify as a complainant under the definition.

Agency Response: The definition of "complainant" mirrors the statutory definition in Insurance Code §1305.004(a)(4). The definition does not preclude an agent or assignee from filing a complaint.

§10.2(a)(6): A commenter would like to see a further move toward the standardization of credentialing by all parties with procedures being subject to open records and specific time limitations for notification.

Agency Response: The definition of “credentialing” mirrors the statutory definition in Insurance Code §1305.004(a)(6), which does not include a time limitation for notification or address whether the records are subject to disclosure under the Public Information Act. The department handles open records requests on a case-by-case basis in accordance with the Public Information Act, but will not generally possess the credentialing records of each provider that has contracted with a network.

§10.2(a)(7): A commenter requests that the definition of “emergency” needs elaboration for circumstances in which an injured worker goes to an emergency room on weekend or after work hours. The commenter feels that there should be more clarity as to who determines if the emergency room visit is defined as an emergency instead of a means to receive care outside the network.

Agency Response: The rule defines “emergency” as “…either a medical or mental health emergency.” The rule does include definitions for medical emergency and mental health emergency to provide the additional clarity the commenter seeks.

§10.2(a)(14): A commenter commends the department for including a broad definition of the term "live." Another commenter requests that the definition of “live” specify whether the term applies to the pre-injury or post-injury location.

Agency Response: The department appreciates the supportive comment. The definition of “live” applies before or after an injury, but is likely going to be an issue once an injury has occurred, as the definition is an integral part of determining whether an injured employee is required to seek treatment from network providers.

§10.2(a)(14): Another commenter states that the definition of “live” should address the distance an injured worker can be expected to travel to receive care, noting that the reimbursement threshold that TWCC has used historically was 20 miles.

Agency Response: The access standards are set out in §10.80. Injured employees must be able to obtain care within the required mileages. The 20-mile reimbursement threshold for travel expenses is not a medical benefit and, therefore, is outside the scope of these rules. The commenter may refer to the Division’s rule at 28 TAC §134.6, relating to travel expenses incurred by the injured employee, which will continue to apply until amended or repealed.

§10.2(a)(14): A commenter states that the definition of the term “live” should be changed to indicate that if any of the three definitions are met, it shall be deemed that the injured employee lives in the health care network area of service.

Agency Response: The department declines to make the requested change, as the change would result in employees not being allowed to temporarily establish a residence outside the service area when so required due to work or injury. In many circumstances, it would not be reasonable to expect an employee to travel into the

service area to receive health care. The definition recognizes this and provides the necessary flexibility for employees who are temporarily outside the service area due to work assignments or recovery from an injury.

§10.2(a)(14): A commenter states that the definition of the term “live” needs clarification to avoid creating a loophole that enables injured employees to avoid receiving their treatment from the healthcare network and to prevent “bad player” doctors who will not be able to participate in networks from encouraging and assisting injured employees with finding a temporary residence for the purpose of receiving necessary assistance with routine daily activities (e.g. out-of-network healthcare).

Agency Response: Although some interested parties may see temporary locations as a potential loophole for fraudulent employees or providers, the absence of a temporary allowance in the rule would operate as an unreasonable restriction on an employee’s right to receive health care services for a compensable injury. Additionally, temporary locations where an employee may live aid in the goal of providing necessary care in an effort to return the employee to work in a more efficient and expedient manner. Delaying care may delay the return-to-work date for an injured employee and unnecessarily punishes an employee who is attempting to return to a job that requires temporary assignments to new locations and an employee who is attempting to recover from an injury in order to return to work. By including a mechanism through which a carrier may contest an employee’s assertion that the employee lives outside the

network, the adopted rule strikes a balance between avoiding potential fraud and delivering necessary care to an employee who is forced to temporarily relocate.

§10.2(a)(14): A commenter requests that the department change the definition of “live” at §10.2(a)(14)(A) to include the terms “fixed” and “permanent” to describe the principal place of residence. The commenter requests that the phrase “temporary residence necessitated by employment” be replaced by “temporary residence required by the employer.” The commenter also requests that the term “activities of daily living” replace the term “routine daily activities.”

Agency Response: The addition of “fixed, permanent and” before “principal residence for legal purposes” could unfairly impact some workers with seasonal jobs, or employed students who attend school out of town, for example. Further, the proposed change of temporary residence “necessitated by employment” to a temporary residence “required by the employer” could unfairly burden an individual who no longer works for the employer at the time of injury but travels due to new employment or self employment. The department recognizes that an injured employee may need to change residence to procure assistance with the activities listed in the definition of “routine daily activities.” Because the definition is reasonably clear, the department declines to change the language in the definition of “live.”

§10.2(a)(14): Several commenters request that, in order to prevent fraud, the definition of "live" be revised by adding language to exclude any residence acquired post-injury

solely for the purpose of avoiding inclusion in the network. Another commenter requests that, to address fraud, the definition of “live” be limited to the employee’s principal place of residence, legal domicile, or place of employment and to employees who may move outside the network to avoid network requirements.

Agency Response: The department declines to add the suggested new language because it may be impossible for the network, the carrier or the department to know with certainty or to prove that an employee’s motive in moving to a new residence was to avoid receiving health care from network providers and not for other valid reasons. While a carrier may be able to establish that an injured employee had the opportunity to choose a residence inside the network’s service area, that does not establish that the employee’s sole motivation was to avoid receiving care from network providers. The adopted rule includes the flexibility for an employee to move outside the service area for a variety of reasons. The commenters’ request to place strict limits on an employee’s right to move outside the network will eliminate the flexibility that may be necessary, for example, when injured employees require continued care after an injury and choose to temporarily live with a family member who lives outside the service area. The department declines to restrict an employee’s ability to relocate or to establish a presumption that any post-injury change in residence is invalid or fraudulent.

§10.2(a)(14): A commenter feels that the presumption of the employee’s residence found in §10.61(b) and the definition of “live” in §10.2(a)(14) have a potential conflict if the employee’s residence on file with the employer or insurance carrier does not meet

any of the three prongs of the test set forth in the definition of “live.” The commenter notes that there is no mechanism establishing the party that chooses which prong of the test must be met in any given circumstance. The commenter also points out that there is no definition or standard for a fraudulent or material misrepresentation in this rule.

Agency Response: The department disagrees that a conflict exists between §10.61(b) and §10.2(a)(14). The presumption in §10.61(b) is that any address the employee has filed with the employer is where he or she lives. The adopted §10.2(a)(14) includes language consistent with §10.61(b) that includes the address on file with the employer as the principal residence for legal purposes. The presumed address is either inside or outside of the service area, and the employer must deliver notice of network requirements accordingly. If the employee later chooses to assert that he or she lives outside the service area based on the definition in §10.2(a)(14), he or she may do so by following the procedure outlined in the rule. If the employer or carrier determines at a later date that the employee does not live at the presumed address based on the definition in §10.2(a)(14), the employer or carrier must deliver notice of network requirements accordingly.

§10.2(a)(15): Several commenters request that the definition of “medical emergency” include either a “reasonable person” or “prudent layperson” standard. Some commenters point out that the “prudent layperson” standard for emergency care is used in the HMO and PPO statutes.

Agency Response: The definition included in the rule mirrors the statutory language at Insurance Code §1305.004(13) and (15).

§10.2(a)(16): A commenter believes the definition of medical records of an injured employee should also include records relating to pre-existing medical conditions that may be relevant to treatment of the injury and not be confined only to the "injury."

Agency Response: The definition of “medical records” in the statute does not include records that may be relevant to a pre-existing condition that may or may not be related to the injury. The department declines to extend the definition beyond the statute.

§10.2(a)(18): A commenter expresses confusion regarding the status of a non-risk assuming PPO network and whether it meets the definition of “network” if it is contracting with providers for delivery of services to injured employees, as it is not technically providing health care services and does not appear to meet the definition.

Agency Response: Because only licensed providers can actually provide health care services to injured employees, it is not the intent of the definition to exclude entities that contract with licensed providers in order to provide health care services. Because any “person” may form and operate as a workers’ compensation health care network, it is sufficiently clear that the network itself does not have to actually provide the health care services. Insurance Code §1305.101(a) states that, except for emergencies and out-of-network referrals, a network shall provide or arrange for health care services only through providers or provider groups that are under contract with or are employed by

the network. For clarification, the department has changed §10.2(a)(18) by adding "or arrange for" to the definition of "network" or "workers' compensation health care network."

§10.2(a)(20): A commenter states that the requirement for board certification for an "occupational medicine specialist" will limit the number of participating physicians because there are many qualified physicians who practice occupational medicine but are not board certified.

Agency Response: Insurance Code §1305.301(c) requires that a network have a medical director who is an occupational medicine specialist or employ or contract with an occupational medicine specialist. This requirement does not apply to all participating physicians.

§10.2(a)(22): A commenter states that there are numerous grounds under the statute and rules under which carriers can deny claims (eligibility, employees' failure to comply with various network requirements, medical necessity, and compensability), many of which are beyond the control of the provider. Therefore, the commenter requests that the department should create processes by which providers may ascertain the carrier's liability prior to rendering services. The commenter asserts that providers should have the right to preauthorize any proposed services to avoid denials based on medical necessity and should also be entitled to verify an employee's eligibility and treating doctor status. Another commenter asserts that, to the extent a provider verifies an

employee's eligibility and treating doctor status and preauthorizes the services, the final rules should provide that the carrier is liable for the services provided and may not deny liability on any basis except compensability.

Agency Response: The statute, at Insurance Code §1305.351(c), allows a network to determine which services require preauthorization. Further, the statute specifically contemplates the availability of a retrospective review process throughout Subchapter H of Chapter 1305. The department thus declines to require networks to predetermine any and all potential services. Once a network has preauthorized a service, however, a network may not deny payment due to medical necessity.

§10.2(a)(22): A commenter requests that the definition of "preauthorization" be revised to state that the term only relates to an approval with regard to the medical necessity of the proposed treatment in order to clarify that preauthorization does not relate to issues of compensability of other matters. This clarification is necessary to facilitate understanding and minimize unnecessary disputes among stakeholders over the intent of these regulations. Other commenters request that the definition be amended to include a review of whether the services were related to the injury since insurers are not required to pay for services that are not related to a compensable injury.

Agency Response: Preauthorization of a proposed service is a determination that the service is medically necessary. The statute reinforces this by providing that a denial of a request for preauthorization is an adverse determination that triggers applicable utilization review appeal requirements. Furthermore, the statute does not allow a

network to deny a claim based on medical necessity if the network preauthorized the service.

§10.2(a)(25): A commenter requests that the term “medical necessity” in the definition of “retrospective review” be replaced with the term “health care reasonably required.”

Agency Response: The definition in the adopted rule is consistent with the statutory definition, and the department declines to make the requested change.

§10.2(a)(25): A commenter recommends that the definition of “retrospective review” should be enhanced to include a standard contained within Insurance Code Article 21.58A, §4(i), which would require such reviews to be made in accordance with currently accepted medical or health care practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria or guidelines. Other commenters request that the definition of retrospective review include a reference to the "relatedness" as well as the reasonableness of health care.

Agency Response: The department declines to make the change. The definition in the rule mirrors the definition provided in the statute. Furthermore, Insurance Code §1305.352 provides that retrospective review determinations shall be based on written and periodically updated screening criteria that include appropriate involvement from doctors, including practicing physicians. This standard is not included in the definition but nevertheless does apply to the retrospective review process.

§10.2(a)(26): Commenters request that “working” be added to the list of items in the definition of “routine daily activities.”

Agency Response: The department declines to make the requested change. Employees are required to participate in the network only if they live in the network’s service area. Adding “working” to this definition would nullify that limitation.

§10.2(a)(27): A commenter requests that the definition of rural area accommodate the many cities in Texas that have populations of 75,000 - 100,000 but should still be considered rural. Another commenter requests that the department clarify whether county population should be determined based upon the 2000 census or a more current estimate or periodically adopt a list of counties meeting the rural population threshold.

Agency Response: The rule incorporates the definition from Insurance Code §1305.004(22) and does not designate any other area as rural. The department will monitor whether areas other than the areas defined by statute should be included within the definition of “rural” for future rulemaking if necessary. The department clarifies that the most recent US census should be used to determine county population.

§10.2(a)(29): A commenter believes that the definition of “service area” should specify a distance an injured worker can be expected to travel to receive care.

Agency Response: The term "service area" refers to the counties that a network may serve and does not relate to the distance a person who lives in the service area must

travel to receive care from a network provider. The commenter's concern is addressed in the access standards provision of the statute at Insurance Code §1305.302.

§10.2(a)(32): A commenter requests that the definition of "utilization review" be changed to: "a system for prospective or concurrent review of the health care reasonably required to treat an employee's injury."

Agency Response: The definition in the rule is identical to the statutory definition, which references the definition in Insurance Code Article 21.58A. The department declines to make the requested change.

§10.2(b)(6): A commenter requests that the department include the definition of "evidence-based medicine" and the other definitions referred to in Labor Code §401.011 in the rule so that there is evidence of clear and unambiguous meaning and to ensure continuity between networks in regard to guidelines.

Agency Response: The reference to the Labor Code definitions provides adequate clarity to all interested parties, as the definitions in the Labor Code are clear and understandable. In incorporating the definitions by reference, the department has attempted to avoid unnecessary repetition of the statutory language. The department, however, has included statutory language when needed for clarity. The Labor Code definitions are appropriate for reference and do not add ambiguity to the rules.

§10.20: A commenter states that the statute and rules specifically prohibit a person from operating or performing any acts of a workers' compensation healthcare network unless certain specified conditions are met, yet there is no enforcement mechanism included in the proposed rule. The commenter is concerned that the rule does not indicate what action will be taken against the carriers that continue to operate informal voluntary networks without proper certification and believes that this issue will be particularly important in "non-network" areas of the state.

Agency Response: The department is currently considering its enforcement options. To the extent there is any limit to the department’s ability to enforce Insurance Code Chapter 1305, other means, including referral to the Office of the Attorney General, may be considered.

§10.20: A commenter asks whether the carrier, employer and PPO can apply jointly for certification and if this is permissible, whether the network can become certified and then add the carrier and employer.

Agency Response: The certification requirements in Insurance Code Chapter 1305 do not contemplate this type of certification. If a carrier contracts with a single network in one service area, the network must be certified. However, if a carrier contracts with more than one network to serve a single service area, the carrier itself must be certified regardless of whether the networks are individually certified.

§10.20: A commenter states that based on §10.20, if a non-risk assuming PPO network is not allowed to file for certification as a workers' compensation network, it also is prohibited from: (1) operating or performing any act of a workers' compensation network, such as advertising that it provides a workers' compensation network (albeit uncertified); and/or (2) contracting with providers and/or clients for referral of enrollees for workers' compensation health care services to workers' compensation certified providers.

Agency Response: Any person who meets the requirements of the statute and rules may apply for and obtain certification as a workers' compensation health care network. The definition of "person" in the rules at §10.2(a)(21) is broad enough to allow a non-risk assuming PPO network to apply for and obtain certification. If an entity, including a non-risk assuming preferred provider network, seeks to operate or perform any act of a workers' compensation health care network in this state, including those mentioned by the commenter, it must be certified.

§10.20: A commenter asks if a PPO that does not operate as a workers' compensation health care network as defined in HB 7 may grant access to contracted rates for services rendered under the workers' compensation statutes. The commenter asks if a PPO which only provides access to contracted rates for participating providers and payors is in conflict with the provisions of HB 7.

Agency Response: The commenter appears to be addressing voluntary networks, which are not allowed under HB 7. The specific statutory requirement that any person

operating or performing the acts of a network be certified by the department, coupled with the broad definition of “network” in both the Texas Labor Code and Texas Insurance Code and the repeal of §408.0223, Texas Labor Code, support the conclusion that voluntary or “informal” networks must be certified to continue providing or arranging for medical care to injured employees.

§10.20: A commenter states that many self-insured employers contract with third party administrators (TPAs) to perform many of the managerial administrative functions. Some TPAs or insurance companies offer administrative services to their self-insured clients. The commenter asks that the rules explicitly recognize third party administrators and states that third party administrators are eligible to apply for certification as workers' compensation provider networks.

Agency Response: The department declines to make a change to the rule because any third party administrator who is a person, as defined by Insurance Code §1305.004(a)(18) and §10.2(a)-(21), is eligible to apply for certification as a workers’ compensation network.

§10.20: A commenter believes that the exception to certification for prescription services should be expanded to apply to the provision of durable medical equipment and recommends the addition of new subsection (c) that would allow providers, carriers, or employers to contractually assign or outsource claims processing, billing, collections,

or fulfillment of durable medical equipment benefits or services deemed medically necessary and appropriate.

Agency Response: The department declines to make the requested change, as Insurance Code Chapter 1305 does not exempt any entity from the requirements for certification set forth in Insurance Code §1305.051(b). The department notes that durable medical equipment (DME) is not a pharmacy service. The Labor Code §401.011(19) describes pharmaceutical services to include a prescription drug, medicine, or other remedy. Therefore, despite the prohibition set forth in Insurance Code §1305.101(c), pharmacies may contract with certified networks to provide DME to injured employees. In addition, the rule does not prevent providers, carriers, or employers from outsourcing the other functions mentioned by the commenter, as those would occur in the non-network setting.

§10.20(a)(1): A commenter seeks clarification of the meaning of the phrase "any act of a workers' compensation health care network." Another commenter notes that the prohibition against an entity "performing any act of a workers' compensation health care network" using certain terms, including "workers' compensation," is problematic because what constitutes an "act" of a network is not defined. The commenter states that many activities performed by networks (e.g., utilization review) are explicitly permitted for other entities under the Labor Code.

Agency Response: Section 10.20(a)(1) (§10.20(1) as adopted) is consistent with Insurance Code §1305.051(b), which states that a person may not perform "any act of a

workers' compensation network . . . ." Insurance Code §1305.004(16) and §10.2(a)(18) of the rule as adopted define a workers' compensation health care network as an organization formed as a health care provider network to provide or arrange to provide health care services to injured employees. While the department notes that utilization review and preauthorization services may be provided by the network, these activities do not constitute the acts of a workers' compensation health care network. Any certified utilization review agent may perform these services.

§10.20(a)(2): Some commenters believe that the requirement for certification for any person who contracts with more than one person restricts the ability of insurance carriers to enter into contracts not related to certified network issues. For example, some commenters observe, a carrier can enter into contracts for fees that differ from the promulgated fee guidelines, and such contracts do not appear to have been contemplated in HB 7 as constituting a "network," as envisioned in HB 7. These commenters request that §10.20 be revised to clarify that the definition of "network" does not include such fee arrangements.

Agency Response: The department disagrees that the certification requirements restrict a carriers' ability to enter into contracts not related to certified networks because the rule addresses who must hold the certification if the carrier contracts with multiple entities to provide or arrange to provide health care services in a service area. Any person or insurance carrier who provides or arranges to provide health care services to injured employees in a particular service area by contracting with more than one

certified network, provider group, or other entities, or combinations thereof, must hold a certificate as a workers' compensation health care network. The department recognizes, however, that Labor Code §413.011(d) allows an insurance carrier to directly contract with a health care provider outside of a certified network for fees either above or below the Division's medical fee guideline.

§10.20(a)(2): A commenter requests clarification on who can establish or contract with a network. The commenter states that the provision applies to a "person" defined as: "any natural or artificial person," which would include an insurance carrier, third party administrator, or other managed care entity that provides or arranges for health care services to injured employees. However, the commenter notes that §10.1(b)(2) states that Chapter 10 applies to "...an insurance carrier as defined by Labor Code §401.011 that establishes or contracts with a workers' compensation health care network." Because the definition of an insurance carrier does not include third party administrators or other managed care companies that provide or arrange for health care services, the commenter requests that the section be revised to include "a third party administrator or other managed care entity."

Agency Response: The department disagrees that the suggested language is necessary because Chapter 10 also applies to any "person who performs a function or service of a workers' compensation health care network . . . including a person who performs a function or service delegated by or through a workers' compensation health

care network," which could include a third party administrator. Thus, a third party administrator may apply for and obtain certification as a network.

§10.20(b): A commenter believes the Act contemplates that networks may contract with a pharmacy benefit manager to deliver pharmacy services, and that the Act exempts the pharmacy benefit manager from workers' compensation network certification. The commenter also states that the Act does not prohibit workers' compensation provider networks from offering prescription services. The commenter recommends that the rules be clarified to ensure that pharmacy benefit managers and other entities that workers' compensation networks hire to arrange for workers' compensation pharmacy services are not treated differently than any other entity offering similar services in the commercial market. Thus, the commenter recommends revising the subsection to require that "persons who contract with more than one person to provide or arrange to provide prescription medication services, while not needing to be certified, must still abide by all laws and rules relating to the delivery of pharmacy services and benefits."

Agency Response: The department disagrees that workers' compensation health care networks may contract to provide pharmaceutical services to injured employees. Insurance Code §1305.101(c) states that notwithstanding any other provision of this chapter, prescription medication or services, as defined by Labor Code §401.011(19)(E) may not be delivered through a workers' compensation health care network. Consequently, the department declines to make the suggested change.

§10.20(b): A commenter suggests language to "further clarify the legislative intent of HB 7 to exempt pharmacy" from network certification requirements. Specifically, the commenter requests that language be included in the subsection stating that "subsections (a)(1) and (2) do not apply to the agents or assignees of providers, carriers, or employers in the provision of prescription medications or services." The commenter believes this change would preserve an injured worker's access to pharmaceutical care and provide consistency in the delivery of prescription medications and services.

Agency Response: The department declines to make the requested change as Insurance Code §1305.101(c) does not exempt pharmacies from the certification requirements. Rather, it states that prescription medication or services, as defined by Labor Code §401.011(19)(E) may not be delivered through a workers' compensation health care network. Consistent with the provisions of Insurance Code §1305.101(c), the activities referenced in §10.20 do not include those relating to the provision of prescription medication or services. The department has amended proposed §10.20(a)(2) (§10.20(2) as adopted) to state that the section applies only to those entities that provide network health care services. As a result of the amendment to proposed §10.20(a)(2) (§10.20(2) as adopted), the department has deleted subsection (b) as unnecessary.

§10.21: A commenter recommends adding language to the rule that would make charging a provider an application fee by the network a violation. The commenter reports that newly forming networks are marketing membership to providers, charging fees as high as $3,000 per applicant, and will not be able to apply for certification until January 2006.

Agency Response: The department declines to add the suggested language. The department believes that any change to the rule in response to this comment would be a substantive change to the rule and would not allow all interested stakeholders to comment.

§10.21(a): A commenter requests that multiple affiliated carriers be allowed to submit one application, certifying each member of the group since the affiliated companies are sharing the same systems and resources. Another commenter believes that the proposed non-refundable fee should include a provision indicating that the initial fee covers the application for an entire carrier group (not per "underwriting entity") or entire business entity that may have multiple service models for its clients. The commenter recommends that there be one certification with sub-certified addendums. By allowing sub-applications and certifications, the commenter asserts, the department can reduce redundancy and costs. The commenter recommends that the language in §10.21(a) be revised and provides suggested language to reflect that a single application may include a certification that encompasses multiple configuration service offerings where each configuration can be offered singularly or collectively and that carrier groups may file

one application for all of their carriers as long as the carriers are specifically named and any components of the application that are different are clearly delineated.

Agency Response: The department declines to make the requested changes because changes are unnecessary. While Insurance Code Chapter 1305 and the rule do not contemplate that a group of carriers may, as a carrier group, receive a single network certification, the adopted rule would allow one carrier in the group to be designated as the network and apply for certification. The other carriers in the group may contract to use that network. However, if a carrier contracts with more than one network or provider group to provide health care services in one service area, the carrier must file for certification as a network. The carrier may submit one application with multiple attachments relating to the multiple configuration service offerings.

§10.21(a): A commenter recommends that this section be amended as in §10.81(c)(1) to reflect national certifications by NCAQ, JCAHO, URAC, and AAAHC. The commenter feels that the certification requirement provides greater credibility for the networks and providers as well as setting standards needed to reestablish confidence in the Workers' Compensation System.

Agency Response: The department declines to require applicants for network certification to have obtained any national certification prior to submission of an application, as the Insurance Code Chapter 1305 does not require such certifications.

§10.21(a): A number of commenters believe that the $5,000 fee for certification is too high. One commenter states that the fee may be particularly high when considering that a network may have to apply several times if different insurers or partners will provide specific services under the statute. Other commenters state that the proposed fee is excessive when compared to other states' network certification processes. These commenters note that some of the states do not charge applicants at all (e.g., California) and other states' fees range from $500 - $3,000. A commenter believes that such a fee will deter companies considering certification and is not in the best interests of this initiative, as it will result in a decrease in the data that will be available showing the impact of the networks.

Agency Response: The certification fee is a one-time fee, and no additional fees are charged for subsequent filings or for possible onsite examinations, regardless of the number of examinations the department may conduct. The department believes that the fee amount is reasonable. It is based upon the average cost of $4,249 per examination charged to HMOs over the past five years. Additionally, Insurance Code §§1305.251 and 1305.252 provide for examinations of networks and providers or third parties if the commissioner deems such examinations necessary. With regard to the concern that a network may be charged multiple certification fees, there is only one certification fee per network regardless of the number of carriers with which the network contracts. Also, while the amount of other states' application fees may be less, the funding mechanism in some states may involve payments from other sources. In addition, the department notes that other states require certification renewals and

charge renewal fees. The department also declines to charge different fee amounts based on the complexity of the network or the size of the service area because such a change could require the department to charge additional fees subsequent to certification to cover additional costs in certain instances (for example, if a network significantly increases its service area post-certification). The department believes that the charge of a single, one-time only fee at the time of application is less cumbersome for networks than charging different fees at the time of application and then possible additional fees for subsequent filings.

§10.21: A commenter recommends amending §10.21 by adding new subsection (d) to state "By submission of the application, the applicant is confirming that a contractual agreement in which the providers have specifically agreed to provide treatment for injured workers' in the workers' compensation system exists between the applicant and the providers that are listed in the application in accordance with Section §10.22(11)" in order to clarify that providers will not be forced into participating in the new system without ever having affirmatively agreed to do so.

Agency Response: The department disagrees that the new subsection should be added to §10.21. However, the department has made changes to the contracting provisions in §10.42(b) by adding paragraph (14) to require that the provider contract state that the provider specifically agrees to provide treatment for injured employees who obtain workers' compensation health care services through the network that is specifically identified in the contract as a contracting party.

§10.22: A commenter believes that all information required of an applicant and submitted to the department as a part of the application process should be public information and available under the Open Records Act.

Agency Response: The department will comply with the confidentiality requirements in Insurance Code Chapter 1305 and any requirements in the Public Information Act.

§10.22: A commenter expresses support of §10.22(11)(A) and (B). The commenter recognizes that a small but significant population, approximately 15% of injured indemnity workers, according to the Division of Workers' Compensation's Medical Director, account for 80 - 85% of lost time and medical dollars paid. The commenter believes that this important sub-population of patients should be carefully managed to prevent the development of chronic disability and excessive utilization of medical care. The commenter believes that evidence-based medical guidelines indicate that appropriately structured, high quality interdisciplinary rehabilitation programs are the treatment of choice to prevent or turn around the lives of many workers that get caught in the chronic disability mindset. Many of these workers, the commenter notes, can be rehabilitated if they are able to get timely and appropriate interdisciplinary care.

Agency Response: The department appreciates the supportive comment.

§§10.22 & 10.22(3) – (6): Some commenters request that information filed under this section be held by the department as confidential and not subject to disclosure under

the Texas Public Information Act. Some of the commenters specifically request that the rule be revised to ensure the confidentiality of the network-provider, third party delegation, network-carrier, and management contracts. A number of commenters note that the contracts include competitive and commercially sensitive information that if disclosed could foster anti-competitive activity in the market and diminish innovation and efficiency.

Agency Response: The department is required to follow the provisions of the Texas Public Information Act, as well as all other applicable laws in order to protect confidentiality interests. Much, if not all, of the information the commenters seek to protect from disclosure is protected pursuant to the provisions of Insurance Code Chapter 1305. Under §§1305.102(k), 1305.152(a), and 1305.154(a), management contracts, network contracts with providers, and network-carrier contracts, are confidential and not subject to disclosure as public information under Government Code Chapter 552.

§10.22(7): This subsection states that network applicants must submit their financial statements prepared in accordance with generally accepted accounting principles. However, many applicants are likely to be workers' compensation carriers, accident and health insurance carriers, and HMOs, all of which are required to use statutory accounting when preparing financial statements for submission to the department. Requiring the same entity to prepare its financial statements using the two different methods would be unduly onerous and costly.

Agency Response: This requirement is consistent with Insurance Code §1305.053(5), which requires a "financial statement . . . that is prepared using generally accepted accounting practices . . ." and §1305.201, which requires that the network "prepare financial statements in accordance with generally accepted accounting standards . . ." The statute and rule address financial statements at the network level which are separate from consolidated financial statements.

§10.22(7): One commenter believes that because it is a non-risk assuming provider network, with all the workers' compensation certified providers already designated in its system for referrals, a financial statement can be provided, but it would not be the statement that an HMO or insurer would be required to submit.

Agency Response: The department disagrees that a network can determine what type of financial statement it may provide. The rule is consistent with the requirements set forth by the legislature in Insurance Code §1305.053(5).

§10.22(7) & §10.25: One commenter believes that the financial statements and other financial information required for certification are burdensome and unnecessary. The commenter notes that workers' compensation health care networks are not risk-bearing entities, and therefore, do not require the level of monitoring reflected in the proposal. Consequently, the commenter believes that the requirement that any changes to these statements be filed is particularly onerous.

Agency Response: The rule is consistent with the requirements set forth by the legislature in Insurance Code §1305.053(5).

§10.22(7)(E): Some commenters believe that the requirement to submit a financial statement that includes the sources and uses of all funds is excessive for a service organization which assumes no risk of loss and does not pay medical bills.

Agency Response: The rule is consistent with the statutory requirement that financial statements be prepared using generally accepted accounting principles. Nevertheless, in response to comments, the department has deleted the requirement in §10.22(7)(D) for a statement of equity. As adopted, the rule mirrors the statutory requirements under Insurance Code §1305.053(5).

§10.22(10)(B): A commenter recommends that the goals of the quality improvement program be specifically defined.

Agency Response: Section 10.22(10)(B) requires a description of the quality improvement program as required in §10.81, which indicates that the quality improvement program is "designed to monitor and evaluate objectively and systematically the quality and appropriateness of health care and network services, and to pursue opportunities for improvement." Moreover, §10.81(b)(2)(A) requires a work plan to include objective and measurable goals, planned activities to accomplish the goals, time frames for implementation, individuals responsible, and evaluation

methodology." Because quality improvement goals are unique to each network, the department declines to define them.

§10.22(10)(E): Some commenters request that the rules specify that any HMO doctor chosen by an employee as a treating doctor must be of a specialty utilized by the network as a treating doctor. One of the commenters believes that permitting treating doctors to come from alternative specialties would create confusion in the administration of a network and compromise the network's ability to adhere to its standards for delivery quality care.

Agency Response: The department disagrees that the requested change is necessary. Insurance Code §1305.105(b) requires the HMO provider to comply with the terms of the contract and Chapter 1305, Subchapter C. Insurance Code, §1305.103(a), states that a network shall determine the specialty of the treating doctor. Additionally, §10.42(b)(12) as adopted requires that the provider contract address whether the contracting provider is of a designated specialty to be a treating doctor, and if so requires that additional responsibilities of treating doctors be included in the contract.

§10.22(10)(E): A commenter believes that the plan, not the non-risk assuming network, should provide the criteria and procedures for employees to select or change the treating doctor.

Agency Response: The department disagrees. Consistent with the requirements of Insurance Code §1305.104, §10.22(10)(E) requires networks to have procedures to allow the employee to select and change the treating doctor and must provide information regarding that process with the application.

§10.22(10)(E): One commenter is concerned that the provision related to the submission of criteria for the employee to elect to receive treatment from his/her HMO doctor fails to require that the employee make the election prior to the injury. As the network has an obligation to confirm that the HMO doctor will comply with network and applicable statutory and regulatory requirements, the commenter believes this requirement could delay treatment and frustrate the employee. The commenter requests that the rules require an employee to select his or her HMO primary care physician as the network treating doctor prior to an injury.

Agency Response: Section 10.22(10)(E) specifically refers to procedures for employees to select as the employee's treating doctor a doctor who the employee selected, prior to the injury, as the HMO primary care physician or provider. This is consistent with the provisions of Insurance Code §1305.105(a) which allows an injured employee to select as a treating doctor a doctor who the employee selected, prior to injury, as the employee's primary care physician or provider under Insurance Code Chapter 843. Consistent with the statute, the rule does not require the employee to make a selection of the HMO treating doctor as his or her treating doctor for purposes of the workers' compensation network prior to the injury.

§10.22(10)(E): A commenter recommends that the option be broadened and extended to doctors who are not members of an HMO, and to other providers, including physical therapists, with whom an employee has a previous history, so long as those providers meet network qualifications, agree to adhere to all applicable network policies and procedures, and to accept fees that would be paid to in-network providers or out-of-network providers, whichever is less. The commenter believes this would not violate the legislature's clear admonition to avoid "any willing provider" status for provider inclusion in networks, but rather would ensure accessibility for injured Texans to providers who have previously provided them sufficiently good healthcare service to warrant their pre-injury selection.

Agency Response: The department declines to expand §10.22(10)(E) to providers who are not members of an HMO. This would be inconsistent with Insurance Code §1305.105(a), which is specifically limited to treatment by a primary care physician or provider under Insurance Code Chapter 843. However, in accordance with Insurance Code §1305.105(d), the department will monitor this issue as it evaluates network adequacy and will offer recommendations to the 80th Legislature regarding whether to make statutory changes to allow treatment by non-network providers through a preferred provider benefit plan, as defined by Chapter 1301. The statutory mandate is Insurance Code §1305.105(d).

§10.22(11): A commenter recommends that the reference to §§1305.301 - 1305.304 of the Insurance Code be deleted. The commenter believes that medical directors and review doctors should be required to have a valid license to practice in the state of Texas, and, therefore, be subject to review and disciplinary action consistent with Texas statutes.

Agency Response: The department declines to make the requested change as the references are to the Insurance Code provisions relating to network organization, accessibility and availability requirements, quality of care requirements, and guidelines and protocols that are the basis for these rules. Insurance Code §1305.301(c) requires that the medical director be licensed in the United States. It does not require that the medical director be licensed in Texas.

§10.22(11): One commenter asks for clarification concerning the access, availability and adequacy standards mentioned in the paragraph. The commenter also references a provision in a New Jersey regulation that allows PPOs that are not plans to opt out of the state’s workers’ compensation network requirements. The commenter states that a network does not necessarily arrange for the provision of the carrier's entire network, and does not maintain adequacy, availability and accessibility standards, but does provide reports for the carrier/client, showing the extent to which the network meets the carrier's standards.

Agency Response: With regard to the comment concerning adequacy and availability standards, the department refers the commenter to the access and availability

standards set forth in Insurance Code §1305.302 and §10.80. With regard to the comment concerning New Jersey's opt-out provisions, it is unclear if the commenter is requesting that the rule include a similar opt-out provision for certain networks. If so, the department declines to include such a provision because Insurance Code Chapter 1305 does not include it. A network that is performing any act of a workers' compensation health care network in this state must obtain a certificate and must meet the requirements of §10.22, including paragraph (11).

§10.22(11): A commenter encourages the department to restore the language in the draft rule that indicated the type of providers that were to be part of the network provider panel. The commenter believes that much of the treatment for workers' compensation injuries requires the use of treatment modalities provided by durable medical equipment providers and suppliers and that the effective use of such modalities can often reduce costs and help a worker return to work more quickly. Therefore, the commenter suggests that contracts with durable medical equipment and other ancillary service providers also be required for network qualification.

Agency Response: The department declines to make the requested change because the composition of the provider panel is dictated by the requirement to provide comprehensive, medically necessary services to treat a compensable injury. If a treatment or service is determined to be medically necessary, it must be provided. Additionally, if the medically necessary treatment or service is of a nature that requires a particular type of provider or specialist to furnish the treatment, service or supply,

including durable medical equipment and other ancillary service providers, the network must arrange for such specialist or provider, or authorize an out-of-network referral.

§10.22(11): A commenter believes that the phrase "adequacy of the network to provide comprehensive health care services sufficient to serve. . . ." needs clarification. The commenter states that the adequacy definition based on mileage is insufficient to address physical therapy services because "adequacy" for a recurring service such as physical therapy is much different than, for example, adequacy for a neurosurgery specialty. According to the commenter, because physical therapy care is routinely provided two or three times per week for two weeks or more, it would be unreasonable, and frequently counter-productive, to require a physical therapy patient, especially a post-surgical patient, to drive up to 75 rural miles each way, or 30 miles through city traffic to keep these appointments.

Agency Response: The department declines to include any additional adequacy standards for the provision of physical therapy services because the adequacy provisions in the rule mirror Insurance Code §1305.302(g), which does not include distinct adequacy requirements for the provision of those services. However, nothing in the rule prohibits a network from providing medically necessary physical therapy through a home health care agency at the home of a post-surgical patient or contracting with physical therapy providers within a shorter distance.

§10.22(11)(A): A commenter requests that the terms “treating doctor,” “sufficient number,” and “medical specialty” within this section be defined. The commenter also asks that the phrase "all health care services can reasonably be expected to be required to treat injured employees in a timely, effective and convenient manner" be clarified.

Agency Response: The department disagrees that these terms and phrases require definition or further clarification. Section 10.2(b)(13), by reference to Labor Code §401.011, defines “treating doctor” as the doctor primarily responsible for the employee’s health care for an injury. Although the term “sufficient number” has a commonly understood meaning, §10.22(11)(A) indicates that a sufficient number is that number necessary to provide services in a “timely, effective, and convenient manner” and §10.80(b)(2) indicates that a sufficient number is that number needed to “ensure choice, access, and quantity of care to injured employees.” The term “specialty” is a commonly understood term that refers to a physician or other provider who has received specialized training and education in a health care discipline. Whether a network satisfies the requirement that all health care services can reasonably be expected to be required to treat injured employees in a timely, effective and convenient manner will be determined on a case-by-case basis and is, therefore, not subject to definition.

§10.22(11)(A) & (D): A commenter states that information concerning network providers’ hospital affiliations and which doctors are authorized to certify maximum medical improvement changes regularly and is not meaningful in the evaluation of a

network application. The commenter recommends deletion of this requirement. The commenter recommends requiring the network to confirm that it provides adequate access to hospitals and to maximum medical improvement certifications.

Agency Response: The information required in these provisions is necessary for the department to determine the adequacy of a proposed network. Because the commenter's proposed change would leave the determination of network adequacy up to the applicant, the department declines to make the requested change.

§10.22(11)(D): One commenter indicates an understanding that the network configuration must include information regarding which doctors are certified to perform maximum medical improvement and impairment rating services, but states that the information is not readily available to a network entity. The commenter believes that it would be more appropriate for a utilization review entity and/or carriers who make indemnity and return-to-work determinations to provide such information. Therefore, the commenter recommends that the obligation to report such information be delegated to the utilization review entity.

Agency Response: The department declines to require that the utilization review agent be obligated to report which doctors are certified to perform maximum medical improvement and impairment rating services. The department disagrees with the assertion that this information is not readily available to the network. The network is in the best position to obtain the information because the network can and should request

it from providers when they apply to join the network. Additionally, the information is available through the Division of Workers' Compensation.

§10.22(11)(E): A commenter states that the proposed rules do not specifically address access to certain therapies, such as those for chronic pain. The commenter notes that HB 7 requires the Division of Workers' Compensation to "examine whether injured employees have reasonable access to surgically implanted, inserted, or otherwise applied devices" and requires the Division to investigate whether any access barriers exist. The commenter asks that the rules be amended to include this directive from HB 7 so that networks and insurance carriers understand their obligations. The commenter states that given the limited number of providers that perform chronic pain therapies and that specialize in spine surgery, it is important to ensure access to providers qualified and willing to provide the same. The commenter requests that the department add a new subparagraph (E) to require information indicating which doctors are qualified and willing to provide spinal surgery, and which doctors are qualified and willing to provide chronic pain therapies, including the implantation of neurostimulators and intrathecal drug pumps.

Agency Response: The department declines to make the requested change. Workers' compensation health care networks are required to provide comprehensive, medically necessary care to treat a compensable injury. If a treatment or service, including spinal surgery and the implantation of a neurostimulator or intrathecal drug pump, is determined to be medically necessary, it must be provided. Therefore, the

department expects that networks will ensure that they have contracts with the providers needed to perform these services. Additionally, the department will be able to monitor this issue through the complaint process to make sure that medically necessary services are available.

§10.22(13): A commenter believes that the required submission of a business plan and two years of pro forma financial projections is excessive and unreasonable, and recommends that the requirement be deleted. Other commenters believe that this type of business plan would not be applicable to a network that does not bear risk. Other commenters are concerned that the requirement seems to go beyond what is necessary and certainly beyond the department's earlier statement that financial requirements would be minimal.

Agency Response: The department routinely obtains business plans for a wide range of different regulatory functions. Moreover, the department believes that prudently run business organizations will typically already have business plans and disagrees that the requirement is onerous. Conversely, the lack of an articulated business plan exacerbates the risk of an entity’s failure due to general business risks, economic factors, etc. The requirement relates to a description of the applicant’s plans and intended operations so that the department can more fully understand the applicant’s profile and operational objectives. While the department does not agree that the proposed requirement is onerous, a change has been made in response to the public

comments. The requirement for pro forma financial projections has been deleted and replaced with a requirement for projections related to operations and profitability.

§10.22(14): A commenter believes that, because networks are not risk-bearing entities, the required submission of an authorization permitting the department to confirm reported assets is an inappropriate and unnecessary administrative burden.

Agency Response: The department disagrees that the requirement is inappropriate and burdensome. The requirement relates to a routine audit confirmation process that is widely used across many industries. Moreover, the department routinely and efficiently processes these forms for other entities, typically in a matter of days. Nevertheless, in response to the comments, the department has made a change to exempt licensed, risk bearing entities from the requirement, since their assets are already subject to department examination.

§10.22(15): A commenter is concerned that §10.22(15), which requires an applicant to submit the applicant’s plan for provision of care to injured employees who live temporarily outside the service area, is not consistent with Insurance Code §1305.302(j), which states that “[t]he network may not be required to expand services outside the network's service area to accommodate employees who live outside the service area." Because Insurance Code §1305.004(24) defines "service area" as a geographic area within which health care services from network providers are available and accessible to employees who live within that geographic area, the commenter asks

why a network's application must include a plan for provision of care to out-of-area patients.

Agency Response: The rule requires that the certificate application include the applicant's plan for provision of care to injured employees who live temporarily outside the service area, "if applicable." The department recognizes that networks are not required to expand services outside the network's service area to accommodate employees who live outside the service area. However, if a network chooses to contract with a provider to allow an employee on temporary assignment outside of the service area or receiving necessary assistance with daily activities to receive necessary services, it may do so. If a network does not intend to make services available to employees who are temporarily outside of the service area, the network should so state along with its application.

§10.22(15): A commenter requests clarification of both the terms "temporarily" and "if applicable" as used in this paragraph. The commenter asks how a network applicant will know whether this regulatory component applies to it, given the use of the term, "if applicable." The commenter also asks how many weeks or months may constitute "temporary" and what rights the carrier has if the injured employee ends up exceeding that limit or never returns to live within the service area.

Agency Response: The department declines to prescribe any time frames because "temporarily" is not a permanent change as clearly indicated in the definition of "live" at

§10.2(a)(14). Further, this provision only applies if a network chooses to contract to provide out-of-network services for employees.

§10.22(17): A commenter states that, because doctors are not employees of the network, the network should not have to verify that doctors comply with the Labor Code's financial disclosure requirements and requests that the requirement be deleted. As an alternative, the commenter recommends that networks be required to provide information to doctors regarding the financial disclosure requirements. Another commenter also requests that this section be revised to require the network to educate providers regarding their obligations under HB 7. Other commenters stated this requirement is too onerous for a non-risk bearing entity and should be removed.

Agency Response: The department has modified §10.22(17) to require an applicant to provide a plan for obtaining certification of provider filings of financial disclosure with the Division.

§10.22(19): Regarding the applicant's plan for monitoring whether providers have been provided and are following treatment guidelines, return-to-work guidelines, etc., a commenter requests that provisions be made for workers with catastrophic injuries who need therapy and who will most likely not be able to return to work.

Agency Response: Consistent with Insurance Code §1305.304, the rule requires a network to provide as part of the application process the network's plan for monitoring whether providers have been provided with and are following the statutorily required

treatment guidelines, return-to-work guidelines, and individual treatment protocols. The requirement does not address the content of the guidelines nor exceptions to guidelines. In addition, workers' compensation health care networks are required to provide comprehensive, medically necessary care to treat any compensable injury, even a catastrophic one. If a treatment or service is determined to be medically necessary, it must be provided.

§10.22(19): A commenter states that the requirement for the network to submit a plan for monitoring adherence to treatment and return-to-work guidelines and treatment protocols is excessive and should not be required. The commenter believes that networks can take appropriate action with regard to any doctors not adhering to their contractual obligations based on complaints filed with the network or other information received through the quality improvement process. This commenter, along with another commenter, recommends that this section be revised to indicate that the network would be required to educate their providers regarding the provider obligations under HB 7.

Agency Response: Insurance Code §1305.304 requires each network to adopt treatment guidelines, return-to-work guidelines and individual treatment protocols. Further, Insurance Code §1305.152(c)(2) requires a statement in the provider contract that the provider agrees to follow the treatment guidelines as applicable to the employee's injury. The department believes that a network should have a process in place to monitor the provider's performance under the contract and the requirements of

this provision to simply ensure that the providers are meeting this obligation. Accordingly, the department declines to change this requirement.

§10.22(19): A commenter states that the majority, if not all, of the treatment guidelines on the market are out of date and do not take into consideration the severity of the injury, the healing process of the individual patient, or the job requirements. According to the commenter, although treatment protocols are numerous, most are developed by individual physicians or therapists, and historically, guidelines have been misused to deny services or reduce reimbursement; many times a nonmedical person with little or no knowledge about the patient's injury and rehabilitation program has the authority to approve or deny treatment.

Agency Response: The department believes that the concerns raised by the commenter are addressed by Insurance Code §1305.352, which requires that retrospective review of a health care service be based on written screening criteria, including treatment guidelines, must be established and periodically updated with appropriate involvement from doctors, including actively practicing doctors, and other health care providers. With regard to the commenter’s concern about the potential misuse of treatment guidelines, Insurance Code §1305.304 and §10.83(b) specify that a carrier or network may not deny treatment for a compensable injury solely because its treatment guidelines do not specifically address the treatment or injury. Because carriers and networks must provide all medically necessary care, a denial based on the medical necessity of the service may be appealed through the utilization review and

independent review organization processes. This is true even if services fall outside the treatment guidelines.

§10.22(20): A commenter requests that the terms "evidence-based, scientifically valid, and outcome-focused" that are referred to in §10.22(20) be defined. The commenter believes that treatment guidelines and return-to-work guidelines should be nationally certified as evidence-based, scientifically valid and outcome-focused to assure continuity between networks. The commenter requests that the department specify in the rule acceptable guidelines to be used by networks.

Agency Response: Evidence-based medicine is defined in Labor Code §401.011(18-a). The remainder of these terms are commonly understood terms and should be interpreted as such. Under Insurance Code §1305.304, each network has discrete authority to adopt treatment guidelines and return-to-work guidelines. Consequently, the department declines to specifically identify any particular guidelines in the rule.

§10.22(20): A commenter states that there are no published treatment guidelines that are considered to be "evidence-based, scientifically valid, and outcome-focused" for physical therapy for injured workers. Thus, the commenter states, requiring certification by a network medical director that a network's treatment guidelines meet this standard is meaningless when it comes to physical therapy. The commenter recommends that network medical directors submit their guidelines for appropriate scientific peer review

to validate their use and certification. Another commenter recommends that medical directors describe the methodology used to determine the guidelines meet the standard.

Agency Response: The department disagrees that there are no treatment guidelines for physical therapy. The language of §10.22(20) ensures that the network has treatment guidelines in place as required by Insurance Code §1305.304. In addition, Insurance Code §1305.304 and §10.83(b) specify that a carrier or network may not deny treatment for a compensable injury solely because its treatment guidelines do not specifically address the treatment or injury. If a treatment or service is determined to be medically necessary, it must be provided.

§10.22(20): A commenter recommends that if the medical director is unable to provide a description of the methodology, or provides one that does not stand up to scientific scrutiny, the network should institute a system of preauthorizing physical therapy services in order to maintain control of the utilization of physical therapy, while still permitting appropriate care that facilitates safe, timely return to work by injured workers.

Agency Response: The department declines to include a requirement that networks provide a description of the methodology for determining whether a treatment guideline meets statutory requirements as part of the application process as it would constitute a substantive change. The department will monitor and evaluate for future rulemaking purposes. While Labor Code §413.014 requires preauthorizations for physical therapy services, that statute does not apply to workers' compensation networks pursuant to Insurance Code §1305.351(c). While Insurance Code Chapter 1305 does not require

networks to preauthorize services, if a carrier or network does use a preauthorization process, the requirements of Insurance Code §§1305.351-1305.355 and these rules apply. Networks and carriers shall decide which services, if any, will be subject to preauthorization, as set forth in §10.102.

§10.22(20): A commenter suggests that national specialty guidelines that are transparent, peer reviewed, evidence-based, and published by the National Guidelines Clearinghouse should be included as part of the rule.

Agency Response: The networks have the authority under Insurance Code §1305.304 to select treatment guidelines and are not precluded from consideration of national specialty guidelines when making their selection.

§10.22(21): A commenter asks whether the networks should have a medical director on staff. The commenter feels that this point is unclear in the rule and indicates that a medical director on staff is appropriate so that providers could have a direct "peer" to discuss problems they may encounter.

Agency Response: The rule must be read in conjunction with the statute, as all statutory requirements are not repeated in the rule. Insurance Code §1305.301(c) requires each network to have a medical director that is available at all times to address complaints, clinical issues, and any quality improvement issues on behalf of the network.

§10.22(21): A commenter expressed concern that an occupational medicine specialist is the only designated physician who can serve in the capacity of medical director. Some commenters understand that medical directors are supposed to be occupational medicine physicians, but propose that this be opened to other areas and not to just occupational medicine physicians, and should include doctors that are certified, licensed, board eligible or board certified that can treat occupational medicine-type injuries, but are still considered highly-qualified physicians who have significant experience.

Agency Response: Networks have the options under the rule and Insurance Code §1305.301(c) of appointing a medical director who is an occupational medicine specialist, or if the network's medical director is of a different specialty, the network may employ or contract with an occupational medicine specialist to assist the medical director.

§§10.22, 10.41, and 10.60: A commenter requests that §10.22 (Contents of Application) be amended by adding new subsection "(22) an explanation of their process that will ensure that injured workers already receiving care are guaranteed a reasonable transition period during which they can continue to see their current, non-network physician for a minimum period of 120 days and up to 1 year. Injured workers who qualify for this transitional care provision include those under treatment for: a) an acute condition; b) a serious chronic condition, including but not limited to treatment for chronic intractable pain; c) a terminal illness; d) performance of a surgery or other

procedure that was already authorized by the insurer and is scheduled to occur within the following 180 days." The commenter believes that the provision is needed to ensure that the network application delineates how reasonable transition will be allowed. The commenter would also like to add this new subsection to §10.41 (explanation of the process for transitioning injured employees) and §10.60 (explanation of the process to injured workers already receiving care to guarantee a reasonable transition period).

Agency Response: The department declines to make the requested addition as it is inconsistent with Insurance Code §1305.103(c), which states that an employee who lives in 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 must select a treating doctor upon notification by the carrier that health care services are being provided through the network. If the employee does not select a network treating doctor within 14 days after receiving the notice of network requirements, the network will assign the employee a treating doctor.

§10.23: A number of commenters request that if the commissioner does not approve or disapprove an application within 60 days, the application will be deemed approved. One commenter notes that this type of provision is frequently found in department regulations related to other product lines and would be helpful to networks in being able to anticipate timeframes for implementation. Another commenter asks what recourse a network has if there is no response from the commissioner within the allotted time frame.

Agency Response: As provided in §10.23, the department will approve or disapprove an application in accordance with Insurance Code §1305.054(a), which states that "the commissioner shall approve or disapprove the application for certification as a network not later than the 60th day after the completed application is received by the department." The department declines to include a provision "deeming" an application approved because there is no such "deemer" provision in the statute. Unless the applicant requests an extension as permitted under §1305.054(c), the department will approve or disapprove an application not later than the 60th day after the date the department receives the completed application.

§10.24: Some commenters opined that since the network is non-risk bearing, the requirement that the network provide the carrier with an annual financial statement before April 1 of each year should be deleted. According to the commenters, this should be a business decision left to the discretion of the carrier and the network rather than a regulatory one.

Agency Response: The department disagrees with the suggested change. It is the department's interpretation that the statute clearly contemplates that carriers retain ultimate responsibility for compliance with applicable regulatory requirements, including for actions of their contracting networks, and that the carriers will monitor their contracting networks for compliance issues. This interpretation is based on the following statutory provisions enacted in the statute. Insurance Code §1305.154(c)(5) addresses the carriers' ultimate responsibility. Sections 1305.154(c)(6) and (c)(12)

address the carriers' oversight of the networks. Section 1305.155(c)(9) provides that a carrier may reassume delegated functions for non-compliance issues at the network level. Further, §1305.155(g)(1) provides the commissioner with discretionary authority to order a carrier to reassume functions from its contracted network if the network is in a hazardous condition. In part, these requirements reflect the need for the carrier to periodically monitor its contracting networks to ensure that the network is not in a hazardous condition, as such condition may precipitate non-compliance issues in other areas.

§10.24: A commenter states that some requirements, both financial and otherwise, appear to contemplate an HMO-type product, but believes it is intended to look more like a PPO model. The commenter points out that the network has no financial risk bearing responsibility. The commenter states that the Division should err on the side of less regulation and do by rule only what is clearly required by statute to implement the new law.

Agency Response: Insurance Code §1305.201(a) requires networks to prepare financial statements in accordance with generally accepted accounting practices (GAAP) standards. Insurance Code §1305.201(b) allows the commissioner to define in rule the manner in which network financial statements should be filed. It is the department's position that the rules are no more prescriptive than necessary.

§10.24(a): A commenter states that in addition to the current requirements in §10.24(a), the section should also require a list of payments made by date, check number, amount paid, provider, injured employee, date claim was received, and date claim was paid, as well as a list of written complaints/appeals and that network's response. The commenter also requests that this information be made available to participating providers.

Agency Response: The department declines to make the suggested change. The provisions of §10.24(a) substantially reflect the statutory requirements of Insurance Code §1305.053(5), for network financial statements, and the commenter's suggestion is inconsistent with such statutory requirements. In addition, the information the commenter requests relates to claim processing rather than the financial statement requirements of a network.

§10.24(b): One commenter expresses strongly that all records relating to networks should be subject to full public disclosure and requests that a provision be added requiring the network to provide its financial statement to "any individual, group, or association requesting them pursuant to the Texas Open Meetings Open Records Act."

Agency Response: The department does not have the authority to add the suggested language as the legislature, rather than the department, determines whether particular information is subject to the Public Information Act. In addition, the Public Information Act applies only to governmental bodies, and not to private entities. Therefore, a network, which is a private entity, would not be subject to its provisions. In responding

to an open records request relating to networks, the department, however, is required to comply with the provisions of Insurance Code Chapter 1305 and the Public Information Act.

§10.25: A commenter opines that §10.25 must be narrowed regarding what constitutes a change requiring a filing. The commenter believes the language is so broad that it appears, for example, to require a filing any time a doctor enters or departs the network. The commenter believes this would be unmanageable, both for the network and for the department. As such, the commenter requests that a filing should be required if any one of the following events occur: 1) change in ownership of the network; 2) there are changes in contractual relationships with management services contractors or insurance carriers; 3) there are changes in the governing body; or 4) there are material changes to the description of programs and procedures filed in the initial application. Another commenter states that this filing process would be excessively burdensome to networks and recommends adopting a "greater than 10%" threshold for reporting changes within the network.

Agency Response: The department disagrees. The filing requirements as specified are necessary to enable the department to ensure that all network requirements are being met. The department has reorganized the filing requirements in §10.25 for clarification and has changed subsection (a)(3) to read "material modification of network configuration." The department has also changed subsection (b) to require the network to file with the department any other information besides that in subsection (a) that

"amends, supplements or replaces the items required under §10.22...." As a result of this change, a network is not required to receive approval for all changes to network configuration, but rather just to those changes that would affect access to care. The department will monitor this issue through the complaint process.

10.25: One commenter opines that the requirement to file a written request for approval before implementation of a change to network configuration or expansion, elimination or reduction of an existing service area is vague. The commenter asks for clarification as to what would qualify as a change or expansion requiring approval: for example, would a provider terminating be a change requiring approval?

Agency Response: The department has reorganized §10.25 for clarification and changed subsection (a)(3) to require approval for a “material modification of network configuration.” As a result of this modification, a network is not required to receive approval for all changes, but rather just those changes that affect access to care. The department will monitor this issue through the complaint process. Expansion, elimination or reduction of an existing service area relates to the counties in which the network is authorized to do business. Because the counties are listed on the certificate for each network and are made available to the public by the department, any modification to the list of counties must be filed with and approved by the department.

§10.25(b)(3) & (4): A commenter states that the requirement for prior approval of modifications of network configuration and service area creates a huge burden when

applied to the normal turnover expected among providers in any network. The addition of a single provider on the edge of the service area could expand or contract the service area. This also seems somewhat redundant in that the service area is a part of the configuration.

Agency Response: The department has reorganized §10.25 for clarification and changed subsection (a)(3) to require approval for a “material modification of network configuration.” This provision does not require a network to receive approval for all changes, but rather those changes that would affect access to care. The department disagrees that the addition of a provider on the edge of the service area could expand or contract the service area. Because the service area is not tied to location of providers, the addition of a provider on the edge of the service area without a change in the listing of counties in the state in which the network is licensed to do business does not change the boundaries of the service area.

§10.26: One commenter opines that this requirement will be excessively burdensome to networks and recommends adopting a "greater than 10%" threshold for filing modifications to a service area.

Agency Response: The department does not agree that this filing requirement is excessively burdensome. The department declines to adopt any threshold for filing and receiving approval for modifications to the service area because a service area is a listing of counties and ZIP codes where the network is authorized to do business. Any change to a service area requires the commissioner’s approval.

§10.26: Several commenters state that while §10.26 requires a greater detail in reporting, the triggering event is essentially the same as in §10.25 (Filing Requirements) and suggest the department consider an exemption regarding prior approval of the addition or deletion of providers in, or adjacent to, the current service area. Commenters posit the exemption to apply to all of the provisions in this section. According to the commenters, an annual requirement to provide updated information should suffice to provide necessary information to the department.

Agency Response: The department declines to make the suggested change. The service area is the geographical area in the state in which the network is licensed to do business. Because the service area is not tied to providers, the addition of a provider on the edge of the service area without a change in the area of counties in the state in which the network is licensed to do business does not change the boundaries of the service area. Any change to the boundaries of a service area requires the commissioner's approval.

§10.26: A commenter states that this section requires the network to file an application and receive approval from the department for all network expansions and reductions in an existing service area, or the addition of a new service area regardless of the significance of the change. The commenter does not understand why a service area addition would require department approval. The commenter states that networks change on a daily basis, thereby requiring the filing of an application which is unduly

burdensome. The commenter believes the requirements under this section can be accomplished by other means. The commenters suggest that the department could require the network to file an application when there is material change to the configuration of the network which would have an impact on injured employees' access to network providers. With regard to network additions, the commenter recommends that the department impose a standard on the network that requires the network to inform the department of changes on a semi-annual basis.

Agency Response: The department declines to make the requested change. Nothing in §10.26 requires notification to the department of network expansion in an existing service area. The rule requires submission of a change in service area, i.e., the geographic area in the state in which the network is licensed to do business. Because the service area is not tied to providers, the addition or termination of individual providers without a change in the area of counties in the state in which the network is licensed to do business does not change the boundaries of the service area, and therefore is not a modification of the network's service area. Section 10.27 addresses modifications to network configuration.

§10.26: One commenter states that §10.26 should be amended to read that, consistent with the definition of service area, a modification occurs when there is a change in the geographic area for which the network provides services. The commenter states that changes to the network within a service area that do not adversely impact access to care should not be considered a modification to a service area.

Agency Response: While it is correct that the service area is the geographic area or areas in which the network is licensed to do business, changes to the provider network within the approved service area or areas without changes to the geographic area for which the network provides services do not trigger the requirements of §10.26. Certain changes to the network within the service area, however, could trigger the requirements of §10.27 (relating to Modifications to Network Configuration).

§10.26: A commenter states that networks should not have to wait for approval to expand, eliminate, or reduce an existing service area. According to the commenter, more flexibility is needed to support efforts to ensure that networks remain responsive to the changing needs and requirements of injured workers and employers.

Agency Response: The department does not agree that the rule will interfere with networks being able to remain responsive to the changing needs and requirements of injures workers and employers. The service area is the geographic area or areas in which the network is licensed to do business. During the application review process, only the service area specified in the application will be evaluated by the department for compliance. Consequently, to ensure continued compliance with all requirements, the department must evaluate any modification to the approved service area or areas to ensure continued compliance with all requirements.

§10.26: One commenter states that the proposed rule, including §10.26, does not appear to allow products that include less than an entire service area as certified by the

department. Furthermore, the rule does not appear to contemplate the use of customized service areas by those contracting for the services of the certified networks. The commenter notes those utilizing network services might wish to use only certain geographically defined portions of a certified network and requests that the rules be clarified to allow for such configurations. Another commenter states that a network should be able to certify a large multi-county region of the state, but the carrier may have employers who are interested in smaller, perhaps one-county, networks. The commenter requests that the rules allow carriers, networks, and employers greater flexibility with regard to service area arrangements. One commenter supports clarifying that the certification application process will accommodate the simultaneous certification of multiple service areas within one certified network. Another commenter states that a network should also be permitted to present multiple “customized” service areas on a carrier-by-carrier basis for each carrier it has contracted with for simultaneous certification under the Act.

Agency Response: The department believes that the commenters may be confusing service area modifications with modifications to network configuration. Although the rule does not prohibit a customized service area, the department is required to evaluate a customized service area for compliance with adequacy, access and availability requirements. If an applicant is able to include information regarding its customized service areas at the time it applies for certification, the department will evaluate the customized service areas separately for compliance with adequacy, access and availability requirements. If subsequent to certification, a network decides to create a

customized service area, then the network must submit a filing in accordance with §10.27.

§§10.26 and 10.27: Some commenters raised concerns that use of the word “application” in §10.26 and §10.27 could create some confusion as to whether or not a network must tender the $5,000 application fee required in §10.21 when they seek approval to modify their network configuration or service area. Some commenters recommend that the term “modification request” be used instead of “application.”

Agency Response: The department agrees and has changed the term “application” in these sections to “modification request.”

§§10.26 and 10.27: A commenter states the distinction between modifications to “service areas” (§10.26) and modifications to a “network configuration” (§10.27) is unclear as modifications to both require descriptions and maps of service areas, network configuration information, and copies of the form of any new contracts or existing contracts. The commenter requests further clarification regarding the difference between these two terms.

Agency Response: The department does not agree that the distinction between modifications to "service areas" (§10.26) and modifications to a "network configuration (§10.27) is unclear. Changes in service area and changes in network configuration are distinct events. The “service area” is the area or areas in which the network is licensed to do business. An expansion, elimination, or reduction of an existing approved service

area results in the modification of the service area which must be approved by the commissioner. “Network configuration” refers to the adequacy of the network to provide comprehensive health care services sufficient to serve the population of injured employees. Any change to the network configuration that is material to the adequacy of the network to provide comprehensive health care services requires a filing to modify the network configuration as provided in §10.27.

§10.26 and §10.27: A commenter notes that the rule does not establish a fee for modifying a network’s configuration, and the commenter supports the policy determination to not charge a fee for the modification of a network’s configuration. According to another commenter, should the commissioner charge such a fee, there are questions about whether network turnover would be defined as a change. This could be a significant issue in larger networks where such changes could occur often.

Agency Response: The commenter is correct that the filing and approval of network modification will not require a filing fee. The department will not require a filing every time a provider joins or leaves the network. However, should such changes, in whole or in part, alter the ability of the network to provide comprehensive, accessible, available health care services sufficient to serve the population of injured employees, the network would have to submit an application to modify the network configuration prior to the modification so that the department can determine whether the adequacy requirements will be met.

§10.26(a): A commenter feels that only those with the ultimate fiduciary authority within the network should attest to the truth and accuracy of the information in the modification request and recommends that the subsection be changed to specifically state that “The Chief Executive Officer (CEO), Chief Financial Officer (CFO) or President" must verify the application by attesting to the truth and accuracy of the information in the application.

Agency Response: The department declines to make the commenter’s change because the subsection contains language required by the Act in §1305.052(b)(2).

§10.26(c)(2): One commenter opines that the narratives required under this part of the rule should be subject to open records.

Agency Response: The narratives are subject to the confidentiality requirements in Insurance Code Chapter 1305 and the Public Information Act. The department will comply with these requirements.

§10.26(f): Some commenters believe that the notice of network requirements should suffice in place of a signed acknowledgment form.

Agency Response: The department disagrees. If the network expands its service area, it is possible that employees who were formerly not living within the service area of the network will now be subject to network requirements. Therefore, the employer must furnish notice and an acknowledgment form to employees affected by the change

in service area, as required in Insurance Code §§1305.005(d) and 1305.451. Carrier notice requirements in §10.60(b) would also be triggered by such a change.

§10.27: Several commenters express concern about the requirement for approval of “material” modifications to network configuration. According to one commenter, no definition of the term “material” may mean that a network’s change of even a single provider would require an application for approval with the department. The commenter observes that this creates a disincentive for certified networks to add providers or to remove poor-performing providers in order to avoid the hassle of having the resulting modification to the network configuration approved. The commenter requests that §10.27 be revised to include a broad definition of the term "material" to ensure that certified networks have the ability to continue building or improving networks. Another commenter suggests defining "material," as a loss of 25% of the network's contracted providers or the loss of a key trauma hospital facility. Another commenter suggests that "material" be defined and that the phrase "greater than 10%" be included after “configuration.” One commenter opines that there is no justifiable reason why the department should require this information and that no disincentives should be arbitrarily created that would hamper network improvements after certification.

Agency Response: The rule does not require a filing every time a provider joins or leaves the network. However, under the rule, should any changes to the configuration of providers, in whole or in part, alter the ability of the network to provide comprehensive health care services sufficient to serve the population of injured employees, the network

would have to submit an application prior to modification of the network configuration. This is necessary to enable the department to determine whether network adequacy standards are met. At this time, the department declines to define the term “material.” The department will determine materiality by analyzing the documentation submitted by the networks. In addition, defining “material” to mean “the loss of 25%" of the network's contracted providers or “greater than 10%” could lead to limiting the factors by which “material” is evaluated. The department will monitor modifications to determine whether the term “material” should be defined.

§10.27: A commenter requests that the department delete §10.27 in its entirety because in the group health plan arena, the department does not approve changes in network configuration and the Act does not mandate this requirement. In the alternative, to ensure that certified networks can continue to build or improve networks, the commenter requests that §10.27(a) be revised to include the following statement: "A change that does not adversely affect the network’s ability to meet its statutory requirements under Chapter 1305 of the Insurance Code or §10.80 of this section is not material."

Agency Response: The department declines to delete this section. Insurance Code §1305.053(9) requires a network to provide a list of all contracted network providers 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 that the access and availability standards are met.

Accordingly, the department must require these filings to determine and to ensure compliance with the adequacy requirements.

§10.27(a): One commenter states that there should be no need for approval of modifications to network configuration when there has been a gain in providers since this would increase accessibility and availability. The commenter also questions how the department can "approve" changes to network configuration, when the termination of network providers may well be outside the network's control and will almost certainly be outside the department's control. The commenter opines that, because contracting with a workers' compensation health care network is a provider’s voluntary business decision, changes in the network configuration would seem to be handled more appropriately as informational filings than as filings for approval.

Agency Response: The rule does not require a filing every time a provider joins or leaves the network. However, under the rule, should any changes to the configuration of network providers, in whole or in part, alter the ability of the network to provide accessible and available comprehensive health care services sufficient to serve the population of injured employees, the network would have to submit an application prior to modification of the network configuration. This is necessary to enable the department to determine whether network adequacy standards will be met. It is the department's position that the commenter's recommendation is not consistent with the department's statutory obligations. Under the commenter's recommendation, an informational filing would not occur until 30 days after the modification took place, and the department

would not be able to determine network adequacy in time to prevent modifications that would affect the health care needs of injured employees.

§10.27(a): A commenter states that there should be a means by which the public can voice opposition or provide input to the modification of the network configuration.

Agency Response: The statute does not provide a means by which the department can solicit the public's input on modifications to the network configuration. However, the public may provide any input to the department by filing complaints or submitting inquiries to the department. The department utilizes complaints and public inquiries to monitor compliance with insurance laws and department rules.

§10.40: A commenter states that requiring the prior approval of management contracts, including amendments to existing contracts, is unworkable, unnecessary, and expensive, and will create uncertainty and ambiguity in the regulation of networks as well as make networks less responsive to the needs of injured workers.

Agency Response: The legislature in §1305.102(a) requires the prior approval of management contracts. Therefore, any costs are a result of the enactment of the statute, and are not the result of the adoption of the rule. The department is unclear why the commenter believes that the approval process for management contracts will make networks less responsive to the needs of injured workers. However, for consistency with Insurance Code §1305.102, the department is correcting an erroneous

reference in this section and adding language to clarify that the approval is by the commissioner.

§§10.40, 10.41 and 10.42: Some commenters recommend that these sections related to contract requirements contain confidentiality clauses to prohibit public access to proprietary information. Another commenter requests that all function descriptions and reporting requirements outlined in this part of the rule should be available to the public pursuant to the Texas Open Records Act.

Agency Response: Pursuant to Insurance Code §§1305.102(k), 1305.152(a), and 1305.154(a), management contracts, network-carrier contracts, and network contracts with providers are confidential and not subject to disclosure as public information under Government Code, Chapter 552. The department does not have the authority to make available to the public any parts of the contracts that are statutorily confidential.

§10.41: A commenter states that §10.41(a)(6) does not address whether a carrier must first delegate contracting, quality improvement, and credentialing to the network and that §10.41(a)(9) does not address whether the carrier can reassume the provider contracting, quality improvement, and credentialing functions listed in Insurance Code §1305.154(b) of the statute. Therefore, the commenter requests that the rules be changed to consistently state that the responsibilities and functions of a network are only those delegated by a carrier and that a carrier is authorized to reassume any and all functions delegated if necessary, including those set forth in §1305.154(b) of the

statute. Further, the commenter recommends that the rule include a provision that would allow the department to grant a carrier an immediate temporary certification so that the carrier can assume network functions. Another commenter requests that the department clarify the terms “delegated entity” and “delegated functions” to clarify which services may be delegated by both carriers and networks and to state that a network may qualify as a delegated entity of a carrier, while a downstream entity may be a delegated entity of a network.

Agency Response: Under Chapter 1305, a network is exclusively responsible for quality improvement, credentialing, complaints and contracting with providers within the network. These functions are not delegated from the carrier, but the carrier must see that they are performed correctly. A carrier, however, may delegate any other function to the network by contract, but the carrier must perform oversight and reassume the functions if the network fails. A carrier may also delegate functions to third parties, such as utilization review and claims payment processing. A network may delegate its exclusive functions or any delegated function to a third party. Section 10.41(a)(9) requires network-carrier contracts to include a provision establishing a contingency plan under which a carrier would reassume quality assurance and other functions. Carriers can structure carrier-network contracts to include an assignment clause. The department does not agree that any change is needed in these sections.

Whether delegated or not, a carrier can reassume functions because these provisions specifically address a contingency plan. Section 10.41(a)(9) requires network-carrier contracts to include a provision establishing a contingency plan under

which a carrier would reassume quality assurance and other functions. Carriers can structure carrier-network contracts to include an assignment clause. The department declines to make this suggested change. A network is exclusively responsible for quality improvement, credentialing, complaints and contracting with providers within the network. These functions are not delegated from the carrier, but the carrier must see that they are performed correctly. A carrier may delegate any other function to the network by contract and must perform oversight and reassume the functions if the network fails. A carrier may also delegate functions, such as utilization review and claim payment to third parties. A network may delegate its exclusive functions or any delegated function to a third party.

§10.41: A commenter recommends adding a requirement for carriers to pay in accordance with the network-provider contract because group health carriers and self-insurers accept the contracted discounts, but then add their own claim adjudication rules that are different from those described in the network-provider contract.

Agency Response: The department agrees that carriers and self-insurers must pay in accordance with the network-provider contract and will monitor complaints and consider possible future action, including rulemaking, if the commenter’s concerns materialize.

§10.41(a): A commenter requests that the network-carrier contract contain an additional subsection stating that a reasonable transition period is allowed for certain

injured employees already receiving care, during which they can continue to see their current, non-network physician for a minimum period of 120 days and up to one year.

Agency Response: Insurance Code §1305.103(c) requires an injured worker who is being treated by a non-network provider to select a new provider within 14 days of receiving the required notice of network requirements. The department does not have the authority to make the requested change.

§10.41(a)(3): Some commenters note that §10.41(a)(3) requires the contract to be terminated immediately if cause exists, but that what constitutes cause is not defined. Because this may prevent networks and carriers from working together to resolve problems, one commenter recommends revising the rule to set forth what constitutes cause and require that the breach be repaired within a specified time frame.

Agency Response: The statute in Insurance Code §1305.154(c)(3) requires the contract to be terminated immediately if cause exists. Section 10.41(a)(3) is consistent with the statutory language. The department declines to amend the rule to define cause or to require a breach to be repaired within a specified time frame because a carrier or network may define cause in a contract. This approach allows for more flexibility between the carrier and network in the contracting process.

§10.41(a)(7): A commenter states that it is in the best interest of the public that language be added to subsection (7) to read: (I) data in sections (paragraphs) (C), (E)

and (F) of §10.41(7) are subject to the Public Information Act and shall be provided to interested parties upon request.

Agency Response: The department does not have the authority to add the sugg4ested language as the legislature, rather than the department, determined whether particular information is subject to the Public Information Act. In addition, the Public Information Act applies only to governmental bodies, not private entities.

§10.41(a)(7)(A), (B) and (C): Some commenters request that the monthly reporting requirements in §10.41(a)(7)(A) and (B) be modified so that social security numbers, dates of birth, addresses and phone numbers of employees are not required to be reported because of privacy concerns and state that carriers, due to delegation agreements, already possess this data. Another commenter requests that the original informal draft rule language, which required more data elements than the current version, replace the proposed language to give the department the tools and information needed to thoroughly scrutinize the performance of the networks.

Agency Response: The department declines to either reduce or increase these data reporting requirements. Insurance Code §1305.154(c)(7) requires networks to provide carriers with the data the carrier needs to comply with the reporting requirements of the department and the Division with respect to any services provided under the contract, as determined by commissioner rules. The Division already collects this information, and the department has access to this claim information pursuant to Labor Code Chapter 402.085 (related to Exceptions to Confidentiality).

§10.41(a)(9): A commenter notes that the proposed rules do not include a rule that parallels Insurance Code §1305.155, which generally sets forth the process for ensuring that a network complies with the network-carrier contract. The commenter asserts that, to the extent that §1305.155(g)(3) refers to selection of treating doctors under the ADL, the rules should clearly state that this option may only be required by the department if it is included in the applicable network-carrier contract's contingency plan. This is consistent with the enforcement powers granted to the department by Chapter 1305, which permit the department to require a carrier to comply "with the contingency plan required by §10.41(a)(9), including permitting an injured employee to select a treating doctor" from the ADL. If the department has approved a contingency plan that does not include this option as part of the network certification process, then the commenter suggests that the carrier should be required to enforce only the provisions of the contingency plan, as approved, and should not be required to permit employees to use the ADL to select treating doctors.

Agency Response: Insurance Code §1305.155 gives the commissioner the authority to order a carrier to take any action necessary to ensure that the carrier can provide all health care services under the Texas Workers' Compensation Act. Whether a carrier's filed contingency plan is sufficient to provide those services will be determined on a case-by-case basis in accordance with §1305.155.

§10.41(a)(9): A commenter states that the requirement for a contingency plan includes the network function of payment to providers and requests that this provision be deleted because networks do not pay providers.

Agency Response: The department agrees with the commenter's concern and is adding the language "as applicable" to §10.41(a)(9)(A) for clarification. The "as applicable" language is necessary because some networks may perform payment functions under a delegation agreement with a carrier, in which case this function would be applicable.

§10.41(a)(9)(D): A commenter states that there should be no need for retrospective review if services are preauthorized.

Agency Response: The department agrees because Insurance Code §1305.153(b) prohibits retrospective review of a health care service that has been preauthorized by an insurance carrier or network, except for reasons other than medical necessity. However, not all services will be subject to preauthorization, and therefore this language is necessary.

§10.41(a)(15): A commenter asserts that it is in the public's interest to make all complaint documents available under the Public Information Act. The commenter recommended a language change to require that the documents be made available to the carrier and any requestor upon request.

Agency Response: The department declines to make the change. The Public Information Act is applicable to governmental bodies, and not private entities. The networks have possession and control over the complaint log and complaint files, which are not subject to open meetings and open records laws. Insurance Code §1305.403(d) specifies that the complaint log and complaints are available to the department during any investigation or examination of a network, but does not provide for any other disclosure of the complaint documentation (except for the complainant for information related to the complaint). It is the department's interpretation that the department does not have the authority to provide for any further disclosure than that provided in the statute.

§10.41(a)(15): A commenter requests that §10.41(a)(15)(B) be changed to make the complaint log and complaint files available to the carrier and the provider within 30 business days of written request. Another commenter states that the requirement for a network to make complaint files available should be restricted to that information in those files as is permitted under applicable privacy, confidentiality, and security laws. The commenter believes such a limitation will assist in clarifying what information can actually be made available under this regulation.

Agency Response: Section 10.41(a)(15)(B) requires networks to make the complaint log and complaint files available to the carrier upon request. The department has added the phrase “to the extent permitted by law” at this end of the provision. The department disagrees that the complaint log and complaint files should be made available to the

provider. A provider may access the report prepared by the workers' compensation research and evaluation group, under Labor Code §405.0025(c), which will provide information on the impact of workers' compensation health care networks on injured employee satisfaction and the frequency, duration and outcome of complaints and disputes regarding medical benefits. No additional change is required.

§10.41(a)(18): A commenter suggests that, in order to ensure the continuation of benefits for insureds whose carriers become insolvent, the network-carrier contracts should also include language requiring cooperation with the guaranty fund, and suggests adding language requiring a statement that the institution of delinquency proceedings against the carrier resulting in the transfer of claims handling responsibility to a receiver or the Texas Property and Casualty Insurance Guaranty Association or similar association in another state shall not constitute any event for which the contract may be terminated for cause and other related language.

Agency Response: The department notes the commenter's concern for ensuring the continuation of benefits for injured employees. However, Insurance Code Chapter 1305 and these rules do not directly address the insolvency of an insurance carrier. Adding this subject matter to the rule would be a substantive change and would not allow all interested parties to comment on the change The department will monitor the issue for future rule making. The department notes that in the event a network terminates its contract because of delinquency proceedings against the carrier, injured employees could access care from an ADL doctor.

§§10.41(a)(19), 10.42(b)(13), and 10.60(g)(16): A commenter recommends adding new language in three sections to require that networks ensure that injured employees have reasonable access to surgically implanted, inserted, or otherwise applied devices or tissues and to state that the Division shall periodically examine whether reasonable access exists.

Agency Response: The department believes the commenter's recommendation is contrary to the statute. Labor Code §413.011(i) provides that the Division of Workers' Compensation shall examine whether injured employees have reasonable access to surgically implanted, inserted, or otherwise applied devices or tissues and investigate whether reimbursement rates or any other barriers exist that reduce the ability of an injured employee to access those medical needs. The Division shall recommend to the legislature any statutory changes necessary to ensure appropriate access to those medical needs.

§10.41(b): One commenter agrees that §10.41(b) accurately reflects the rights and authorities of a network by stating that a network's authority to perform a function under a network-carrier contract is conditioned upon whether the carrier has delegated that function to the network in the contract and whether the network is appropriately licensed to perform that function.

Agency Response: The department appreciates the comment. A carrier does not have to delegate credentialing to a network, but the carrier can reassume this function

and may add this to the contingency plan, which is intended to address reassumption of functions. A network may also include an assignment clause in the provider contract. Absent an assignment clause, the use of providers on the division's ADL under Labor Code §408.023 may be required.

§10.42: A commenter requests language that will address implementation of a card, similar to a group health plan card, identifying the necessary information to process health care services to the injured employee, requesting that such a card include: employee name; employer name and/or employer group number provided by network or carrier; workers' compensation health care network name or logo; telephone number for verification of employment status; claim submission address; telephone number for authorization and/or precertification; carrier name; and effective date of coverage. The commenter suggests that the card can be coordinated with any state program, as it relates to tracking necessary information. Absent such a card, the commenter requests that language should be included in the contract between the provider and network as to how pertinent information can be identified.

Agency Response: The statute does not include a requirement for identification cards to be issued by carriers or networks. The department declines to create a new requirement that carriers or networks issue such cards or that any cards issued include any specific language. Networks and carriers are not precluded from voluntarily issuing cards. The provider and the network can negotiate how the pertinent information is to be identified in their contract.

§10.42: A commenter requests information to clarify who is responsible for notifying the member that a provider is terminating from the network when a carrier or employer uses a PPO. The commenter also asks how a PPO can continue operations during the transition period if PPOs cannot operate or market themselves as a workers' compensation health care network.

Agency Response: Section 10.42(b)(6)(G) provides for the network to notify employees receiving care of the provider's termination or contract expiration. A PPO that operates as a voluntary health care provider network for the purpose of arranging for and providing health care services to injured employees may not operate or perform the acts of a network, as defined by the Texas Labor Code and Texas Insurance Code, after January 1, 2006. Applications for certification as a workers' compensation network will be accepted by the department starting January 1, 2006.

§10.42: A commenter states that the final rules for workers' compensation should include the prompt pay language related to 30 days for electronic claim submission and 45 days for paper claims. The commenter further states that the final rules should also include the group health penalty language for failure to pay promptly and accurately.

Agency Response: The legislature has set forth a carrier's reimbursement requirements for network care in the statute at Insurance Code §1305.106, which references Labor Code §408.027, and Insurance Code §1305.153. These requirements are the specifically applicable prompt payment requirements for workers' compensation

health care network services. The department does not have the authority to substitute the PPO/HMO prompt pay requirements for these statutorily mandated requirements.

§10.42: Although a commenter does not want the department to require that the employer or carrier have an identification (ID) card for every single employee, the commenter acknowledges there needs to be some way to identify that injured worker when the worker schedules an appointment. The commenter encourages the department to explore different options so that there is an easy way to identify the patient is eligible.

Agency Response: The purview of these rules does not include how providers are to identify injured workers upon scheduling an appointment. The department will take this comment into consideration and monitor the situation for future rulemaking as necessary.

§10.42: A commenter states that antitrust regulations prohibit providers from discussing any fee information or proposed fees with any other provider. The legislature included in HB 7 a clause that allowed a network to revise insurance company status for the purposes of negotiating contracts because a network must negotiate a contract with both its providers and also with the insurance companies. The commenter asks that the department consider that any entity that is contracting with providers in an effort to become a network would likewise be included in this exoneration of physician antitrust problems.

Agency Response: Insurance Code Chapter 1305 and Chapter 10 require networks and providers to contract in accordance with other state and federal laws. The department's jurisdiction does not extend to antitrust regulations.

§10.42: Some commenters recommend that the department include the protections created by Insurance Code §1305.153(e) as a mandatory contracting requirement in §10.42 in order to prevent confusion among carriers, networks, and providers. In the event the department chooses not to address §1305.153(e) because it relates to compensability, the commenters urge the department to work with the new Division of Workers' Compensation to address this issue in future rulemaking.

Agency Response: The department declines to make the requested change. The absence of the language in the rule does not affect the applicability of Insurance Code §1305.153(e), as the language in the rule indicates that billing and payment must be performed in accordance with all applicable statutes and rules. However, parties are not precluded from including such a provision in the contract.

§10.42: A commenter requests that the department include a provision indicating that an injured worker or provider is subject to potential liability for administrative or criminal penalties if it is determined that health care services were received, or payment was collected for such services, through acts of fraud or deception.

Agency Response: Nothing in the statute or these rules indicates that a party is exempt from any applicable penalties if a party is determined to be in violation of the

Workers' Compensation Act or the Penal Code. The department declines to make the requested change as additional language is not necessary.

§10.42: A commenter requests that the rules specifically implement Insurance Code §1305.1545 and, in particular, §1305.1545(b).

Agency Response: Insurance Code §1305.1545(a)(2) makes reimbursements on a discounted fee basis contingent upon a provider agreeing to the terms of the contract. Subsection (b) prohibits a party to a network-carrier contract from selling, leasing, or otherwise transferring information regarding the payment or reimbursement terms of the contract without express prior approval. The department has added some clarifying language in §10.42(b)(14), to ensure that the network-provider contract include a statement that the provider specifically agrees to provide treatment for injured workers who obtain workers' compensation health care services through the network that is specifically identified in the contract as a contracting party.

§10.42(a): A commenter requests a response or clarification as to the operation of this rule, originating from Insurance Code §1305.152(b). The commenter is concerned that the rule could be interpreted to imply that a network would be required to accept provider into the network if the provider applies before the network has contracted with its intended number of qualified health care providers. The commenter assumes that it is not the intent of the statute or the department that this rule would require networks to

accept an application from any willing provider, a concept that was rejected by the Legislature in drafting HB 7.

Agency Response: The department will continue to monitor this issue for future rulemaking. Insurance Code §1305.152(b) does not require that certified networks accept applications from qualified providers if the network determines that it has contracted with a sufficient number of qualified providers. Section 10.42(a) mirrors this statutory language. All applicants must meet the network's credentialing criteria, including those who apply before the network has contracted with its intended number of qualified health care providers.

§10.42(a): Some commenters strongly support §10.42(a), which tracks §1305.152(b) of the statute and provides that a network is not required to accept a provider for participation in the network if the network has a sufficient number of qualified health providers. Commenters request that the rules clearly state that a network has the discretion to determine whether it has a sufficient number of providers and is not required to prove this determination, which the commenters believe is consistent with the department's interpretation of this language for HMOs. A commenter also asks that the rules clarify that a network is not required to provide an appeal process for rejected applicant providers because a notice of rejection is sufficient. The commenter believes such a clarification is consistent with the requirements of Insurance Code §1305.152(c), which only requires a network to provide an appeal for providers whose network provider status is terminated.

Agency Response: The department will continue to monitor this issue for future rulemaking. Insurance Code §1305.152(b) does not require that networks accept applications from qualified providers if the network determines that the network has contracted with a sufficient number of providers. Section 10.42(a) mirrors this statutory language. Thus, the department agrees that a network has no obligation to prove its adequacy to a provider in rejecting an application. The department agrees that providers have no right to appeal a rejected application but believes that the rules are sufficiently clear without the need for additional clarification.

§10.42(a): A commenter states that the requirement for a “sufficient” number of qualified providers leaves a huge loophole for the carrier-networks to choose providers based on whatever criteria the carrier-network chooses. A commenter requests clarification of the entire §10.42. The commenter believes that the only obstacle to a provider’s inclusion in the network should be a provider choice against participation or a provider history of fraudulent practices or overutilization within the traditional workers’ compensation system. The commenter believes that any provider who wishes to participate should be allowed to do so.

Agency Response: Insurance Code §1305.152(b) does not require that networks accept applications from qualified providers if the network determines that the network has contracted with a sufficient number of qualified providers. Section 10.42(a) mirrors the statutory language.

§10.42(a): A commenter feels that, to assure that networks contract with health care providers from each discipline and specialty sufficiently to serve the population served by the network, the department should either establish criteria which consider geographic area, types of industry, and number or workers or should require each network to provide a detailed methodology used by the network to establish the number of providers with whom to contract. The commenter believes that injured workers deserve prompt, appropriate care which can only be delivered if an ample number of providers of all disciplines are part of the networks.

Agency Response: The plenitude of factors that may affect a network's ability to deliver care at any given time weighs against introduction of a formulaic methodology for determining adequacy. The department declines to add a requirement that detracts from the flexibility needed to account for the varying circumstances, such as the urban versus rural nature of a service area or the utilization of services in a particular service area. The department's review of network adequacy focuses on the specifics of a service area and other factors that are particular to the network in question.

§10.42(a) and (b)(5): One commenter states that the network should be protected regarding provider selection and deselection so the network can freely pick doctors; and if doctors don't comply with the rules, the networks can either reeducate them or kick them out of the network without fear of litigation.

Agency Response: Insurance Code Chapter 1305 and the rules provide networks the freedom to select and deselect doctors. Section 10.42(b)(6) as adopted requires a

contractual provision regarding appeal of a provider's network status but does not prohibit the network from deselecting a provider in accordance with the rules. Under §10.42(b)(6) networks may terminate providers immediately in the case of imminent harm to patient health, suspension or loss of license to practice, or fraud.

§10.42(b): A commenter requests that §10.42(b) be deleted as too onerous for providers. Another commenter requests that subsection (b)(12) ((b) (13) as adopted) be changed to require that network-provider contracts include a statement that billing by and payment to the provider will be made in accordance with department rules under Senate Bill 418. Another commenter requests inclusion of a clause requiring networks to provide a minimum 90-day prior written notice to providers of a requested change in contract fee allowable.

Agency Response: The provider contract requirements are largely derived from Insurance Code §1305.152 (related to Network Contracts with Providers). The statute does not apply the prompt payment standards set forth in Senate Bill 418 (78th Regular Session) to services provided under a workers' compensation health care network contract. However, the legislature does impose the standards in Labor Code §408.027 for payment of network providers. The department does not have the authority to make the requested changes.

§§10.42(b)(1), §10.60(e)(2)(B) and §10.60(g)(7): A commenter states that under the statute, a hospital or other providers risk non-payment by the carrier in many situations.

While the commenter believes it is reasonable to prohibit providers from billing employees in those situations in which the employee has no involvement or control, such as the insolvency of the carrier, the commenter believes that the hold-harmless language in §10.42(b)(1) is overbroad and prevents a network provider from billing an employee for health care services for compensable injuries under any circumstances. The commenter believes that §§10.60(e)(2)(B) and 10.60(g)(7), which provide employees with information about the hold-harmless provision, are similarly broad. A commenter recommends that the department revise §§10.42(b)(1), 10.60(e)(2)(B) and 10.60(g)(7) to limit the hold-harmless provisions to those circumstances in which the carrier has not paid the provider due to insolvency or in which the network provider has failed to comply with its contractual obligations. The commenter further recommends that the hold-harmless provisions be changed to allow the patient to pay for services not authorized by the network when the patient has been informed prior to service that the service is not covered and will be the patient's financial responsibility.

Agency Response: The language of §10.42(b)(1) is similar to the language in Insurance Code §1305.152(c)(1), which includes the phrase "under any circumstances." The rule clarifies that the health care services must be related to a compensable injury, which expresses the department's interpretation of the statute that injured employees may not be billed by network providers for health care services for compensable injuries. The commenter's suggested change, which would allow the network provider to bill the injured employee if the carrier failed to pay the provider according to the terms of the provider contract, conflicts with the statute. The carrier's breach of the contract

does not allow the provider to pursue payment from the injured worker. The department, however, recognizes the potential for circumstances where the injured worker may be liable for services on a case-by-case basis.

§10.42(b)(2): A commenter states that §10.42(b)(2) requires that network contracts with providers contain language that contractually obliges providers to adhere to the guidelines and protocols utilized by the network and states a belief that there is a lack of treatment guidelines appropriate for physical therapy. For any guidelines and protocols that are imposed by a network, the commenter recommends that, prior to final signature, the network be required to make such guidelines and protocols available to providers as addenda to proposed contracts. Since networks must have such guidelines and protocols in place in order to apply for certification as workers' compensation health care networks, the commenter believes this is a feasible requirement. The commenter states that providers are unable to realistically assess their ability to provide services at the rates proposed without knowing the detail of the network's operating requirements. Another commenter expresses fear that if guidelines and protocols are not reviewed by providers in advance there will be disruptive cancellation and turnover in the provider lists.

Agency Response: Section 10.83(c) requires networks to make adopted treatment guidelines accessible to providers. The department agrees that it would be prudent for a provider to request an opportunity to review such guidelines prior to entering a contract that obligates the provider to follow such guidelines.

§10.42(b)(2): A commenter states that because there are no comprehensive treatment guidelines for physical therapy services for injured workers that meet the requirements of the statute, a provision should be added to §10.42(b) requiring provider contracts to include a statement that requires preauthorization for physical therapy services not addressed in the networks' treatment guidelines, return-to-work guidelines and individual treatment protocols. The commenter believes that the provider's professional judgment and the best interests of the employee may indicate different and/or additional services than those outlined in adopted guidelines. The commenter believes that required preauthorization of services would alert the network and carrier of the need for specific services and allow case management and utilization review to determine what services will be allowed and reimbursed.

Agency Response: The department declines to make the suggested change because the statute does not mandate preauthorization of physical therapy services.

§§10.42(b)(2), 10.42(c): A commenter suggests additional language to require the inclusion in provider contracts of a statement that the provider agrees to provide the health care reasonably required to treat the employee's injury in accordance with Labor Code §401.011(22-a) for injuries not addressed in the network's treatment guidelines, return-to-work guidelines and individual treatment protocols adopted by the network. A commenter also suggests that the term "medically necessary services" in §10.42(c) be

changed to “the health care reasonably required to treat the employee's injury per Labor Code Section 401.011 (22-a).”

Agency Response: The department declines to make the suggested change because networks and carriers are required to provide medically necessary care to an injured employee.

§§10.42(b)(3), 10.60(g)(12)(D)(ii): A commenter has concerns about how complaints from employees and providers will be handled. Sections 10.42(b)(3), and 10.60(g)(12)(D)(ii) state that a network cannot retaliate against an employee or a provider because they have "reasonably" filed a complaint against the network in some form. The commenter believes it is critical to encourage individuals to participate in the complaints process in the statute and thinks it is imperative that injured workers feel that they have the ability to notify decision makers of problems with faith that the complaint will be treated appropriately.

Agency Response: Insurance Code §1305.404 prohibits a network from engaging in retaliatory action against an employer or employee because the employer or employee or a person acting on behalf of the employer or employee has filed a complaint against the network. Section 1305.404 does not include the term "reasonably" in reference to the filing of the complaint. The term “reasonably” is included in the rule to maintain consistency with the provisions of the statute in §1305.451(b)(10)(B), which includes the “reasonably” qualifier for complaints made by providers. This distinction requires a more discerning attitude towards complaints from providers, but does not have a chilling

effect on complaints from employees who do not have the same professional expertise as providers. The department believes that the rule adequately addresses the concerns raised by the commenter.

§10.42(b)(3): A commenter states that the phrase "reasonably filed a complaint" is vague and ambiguous. The commenter is unclear whether the term “reasonably” is meant to indicate a requirement that the complaint be reasonable or a requirement that the manner in which a complaint is filed be reasonable. The commenter requests that the phrase be defined or restated. The commenter also suggests that the word “employee” should be changed to “injured worker.”

Agency Response: The term "reasonably" is meant to characterize the nature of the complaint rather than the method of filing the complaint. The term “employee” is defined in Insurance Code §1305.004(a)(8) by reference to Labor Code §401.012 and is broad enough to include injured workers. The department believes the rule is clear and does not require a change.

§10.42(b)(4)(A): Commenters request the insertion of language to specify that networks, rather than providers, have the authority to determine whether an employee has a life-threatening condition or an acute condition for which disruption of care would harm the employee.

Agency Response: The department declines to make the recommended change. The department believes that physicians and providers who have first hand knowledge of

the employee's health status are best positioned to determine whether the injured employee has a life-threatening condition or an acute condition for which disruption of care would harm the employee.

§10.42(b)(4)(A): A commenter recommends that the term "acute" be defined to avoid abuse and notes that California has defined "an acute condition" as "a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a duration of less than 90 days."

Agency Response: The department declines to make the requested change. The department believes that the term "acute" is so widely used in the medical field as to have a plain, commonly accepted meaning. Whether an injured employee's condition is acute is a question that should be determined on a case-by-case basis, but the department will monitor this issue in order to determine whether future rulemaking is appropriate.

§10.42(b)(4)(A): A commenter suggests adding language to indicate that the requirement for a carrier or network to continue reimbursement of a provider for an employee with a life-threatening or acute condition for which disruption of care would harm the employee may not exceed 90 days.

Agency Response: The language in the rule provides that the time cannot exceed 90 days.

§10.42(b)(5)(A): A commenter recommends that the adopted rules should not include a 90-day notice for terminations for cause.

Agency Response: The 90-day notice requirement is required for all terminations except in case of imminent harm to patients, suspension or loss of license to practice, or fraud. The department believes that the 90-day period allows for a timely appeal process should the provider choose to appeal, and also provides an opportunity during the 90-day period for the provider to cure the deficiency.

§10.42(b)(5)(B): Commenters state that the requirement that the network provide an advisory review panel to review terminations comprised of at least three network providers of the same specialty or similar specialty is unreasonably burdensome. Another commenter states that an advisory panel comprised of network providers within the network is a bad idea. An additional commenter suggests that the required advisory panel should consist of providers with like licenses because the "same or similar specialty" language will leave the panel makeup so ambiguous as to cause disputes. Another commenter believes the term "same or similar specialty" needs to be defined and/or clarified. Another commenter recommends that the panel members should have "the same or similar license and specialty."

Agency Response: The like specialty review panel is used for group health and has been included in the rule to make the network proximate group health services. The adopted rule allows networks greater flexibility by allowing network and non-network

providers to serve as members of the network's advisory review panel. The department agrees that advisory panel members should be of the same licensure as the provider appealing a termination and has changed the rule accordingly.

§10.42(b)(5): A commenter states that it is impossible for the network to know which injured employees are seeing providers in its network, so the network cannot provide notice of termination to injured employees. The commenter further suggests language to state that the network may provide notice to injured employees through updates to the network's provider directory or through provider communications.

Agency Response: The department disagrees. The required contractual provision at §10.41(a)(7) of these rules states that the network must report to the carrier on at least a monthly basis the names, as well as other information of each injured employee who is being served by the network, as well as each injured employee's treating doctor. Therefore, a certified network must have a method for collecting information about injured employees being treated by network providers. The required notice to injured employees receiving care must be given directly to the employees in order to allow them to find another provider. Updates to the provider directory will serve as notice to other employees who are not receiving care from the terminated provider.

§10.42(b)(5): A few commenters request a change to indicate that a provider has no right of appeal for termination based upon the natural expiration of the contract's term.

A commenter also asks whether written notification of the termination should be provided to a provider's patients rather than all employees.

Agency Response: The department agrees and has changed§10.42(b)(5) (§10.42(b)(6) as adopted) to clarify that the required provider contract provision relating to appeal of a termination of network provider status does not apply in the case of a termination due to contract expiration. The department has also added language in §10.42(b)(6) as adopted to clarify that the requirement to give written notification to employees of a provider termination is limited to “employees receiving care” from the terminated provider.

§10.42(b)(5)(G): Commenters request that §10.42(b)(5)(G) be changed to reflect that a network must provide notification of a termination of contract to employees receiving care whether the network or the provider terminates the contract.

Agency Response: The department agrees and has added language in adopted §10.42(b)(6) as adopted to provide that network contracts with providers must include a statement that if the network or the provider terminates the contract, the network must provide notification of the termination to employees receiving care from the terminating provider.

§10.42(b)(6): A commenter asks if the notification to employees regarding the process for resolving a workers' compensation health care network complaint will be provided by or available to all providers through the department, printed in several languages to

accommodate workers who do not read English, to assure standardization of size and statement. If the notification is not available through the department, the commenter requests that §10.42(b)(6) be changed to address all content aspects of the notice.

Agency Response: The department declines to promulgate such a form but will consider making a sample form available on the department's website. The department declines to make the requested change to 10.42(b)(6).

§10.42(b)(10): A commenter recommends that the language in this provision mirror the group health language and include a requirement that the network provide any and all claim adjudication rules in addition to the fee schedule.

Agency Response: The provider protections associated with prompt payment provisions are actually located in Insurance Code §1305.106, which incorporates the requirements under Labor Code §408.027 by reference. The commenter's suggested change can be a negotiated requirement for the network contract with the provider.

§§10.42(b)(10), 10.42(b)(2), and 10.83: A commenter asks which fee schedule applies and requests use of a single fee schedule, stating it will be problematic if there are multiple differing guidelines and protocols providers must follow if the providers contract with multiple networks.

Agency Response: Each networks' fee schedule for each provider will be negotiated during the contracting process. Additionally, Insurance Code §1305.304 requires each

network to adopt its own treatment guidelines and protocols. The department declines to make the requested change.

§10.42(b)(10): A commenter requests clarification about the requirement that the contract include a schedule of fees and asks if this means that the contract must include an actual fee schedule or merely reference a benchmark.

Agency Response: The contract may use benchmarks, including, but not limited to Medicare and Medicaid, as a reference for the fee schedule. The contract also may include a fee schedule for specific billing codes. The format of the fee schedule is subject to the contract negotiation process between the network and the provider.

§10.42(b)(10): One commenter is concerned about the lack of a fee schedule. The commenter states that it is difficult for physicians to be able to practice and to consider treating workers' compensation patients if the reimbursement is going down. Another commenter requests that a reimbursement floor be established by rule. The commenter has concerns about the level of reimbursement when some pre-certification contract negotiation indicates that some networks might offer 85% of Medicare.

Agency Response: Network contracts with providers must contain a schedule of fees that will be paid to contracting providers. Under Insurance Code §1305.153(a), the amount of reimbursement for services provided by a network provider is determined by the contract between the network and the provider or group of providers. The statute does not provide for the establishment of a reimbursement floor by rule.

§10.42(b)(12): A commenter strongly supports §10.42(b)(12) and thinks that provision should require the inclusion of a prompt pay provisions in network-provider contracts, which are similar to those included in the HMO and PPO contracting rules, which will help to ensure that network providers will be paid timely for their services and will be given the ability to enforce their statutory payment rights. The commenter requests that §10.42(b)(12) be changed to encompass the payment protections created by the statute for network providers under Insurance Code §1305.106, to require inclusion in the network-provider contract a provision which states that billing by and payment to the provider will be made in accordance with Insurance Code §1305.153 (related to Provider Reimbursement) in addition to Labor Code §408.027 and other applicable statutes and rules.

Agency Response: The department declines to include a prompt pay provision in network-provider contracts, which are similar to those included in the HMO and PPO contracting rules. The legislature has set forth a carrier's reimbursements requirements for network care at Insurance Code §1305.106, which references Labor Code §408.027, and Insurance Code §1305.153. These requirements are the specifically applicable prompt pay requirements for workers' compensation health care network services. Insurance Code §1305.106 requires carriers to pay claims only in accordance with Labor Code §408.027. Insurance Code §1305.153(d) states that subject to Subsection (a), billing by, and reimbursement to, contracted and out-of-network providers is subject to the requirements of the Texas Workers' Compensation Act and applicable rules of

the commissioner of workers' compensation, as consistent with this chapter, but does not require that any specific statutes or rules be listed in the network-provider contract. Section 1305.153(a) states that the amount of reimbursement for services provided by a network provider is determined by the contract between the network and the provider. The department declines to add a required reference to the language in Insurance Code §1305.153, because portions of the section are not applicable to contracted providers, and those sections that do apply will not be rendered inapplicable by the lack of a reference to the section. The actual contractual provision may be negotiated but must comply with the spirit of proposed §10.42(b)(12) (§10.42(b)(13) as adopted). The department will monitor the situation for possible future rulemaking.

§10.42(b)(12): A commenter asserts that all the prompt pay provisions that exist under SB 418 should be applicable, including proof of filing, penalties for not paying claims on time, and some other issues that have been left out in HB 7. In addition, the commenter believes the network should be able to contract with carriers to include additional prompt pay provisions not included in HB 7. Another commenter supports prompt pay and appreciates every aspect of prompt pay that can be put into rules.

Agency Response: The department declines to make the change to §10.42(b)(12). The legislature has set forth a carrier's reimbursement requirements for network care at Insurance Code 1305.106, which references Labor Code 408.027, and Insurance Code 1305.153. These requirements are the specifically applicable prompt pay requirements for workers' compensation health care network services. Insurance Code §1305.106

states that Labor Code §408.027 (related to Payment of Health Care Provider) applies to a carrier's payment, reduction, denial, or determination to audit a claim for services provided through a workers' compensation health care network. Insurance Code §1305.153(d) states that subject to subsection (a), billing by, and reimbursement to, contracted and out-of-network providers is subject to the requirements of the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation, as consistent with this chapter. Section 1305.153(a) states that the amount of reimbursement for services provided by a network is determined by the contract between the network and the provider. Carriers, networks and providers are not precluded from negotiating additional prompt pay provisions in accordance with Labor Code §408.027 and other applicable statutory and rule provisions.

§10.42(b)(12) and Labor Code §413.011: A commenter encourages the adoption of a fee schedule because it helps to set a threshold from which any contracting can take place and helps the parties to understand the basis from which they are going to start. Another commenter requests that networks be allowed to negotiate with physicians for fees that would exceed the current fee guidelines under the workers' compensation system.

Agency Response: The department does not have the authority to adopt a fee schedule. Insurance Code §1305.153 provides that the amount of reimbursement for services provided by a network is determined by the contract between the network and the provider or group of providers. Section 10.42(b)(12) (§10.42(b)(11) as adopted)

requires network contracts with providers to contain the schedule of fees that will be paid to the contracting provider. The parties are free to negotiate the schedule of fees.

§10.42(b)(14): One commenter indicates concerns regarding the lack of penalties for those who disregard their own contracts; i.e., while the contracts contain prompt payment for clean claims, there is no penalty for untimely payments. On the other hand, the commenter notes that if a provider does not submit a clean claim in the time specified in the contract, payment won't be made.

Agency Response: Pursuant to §10.42(b)(14) (§10.42(b)(13) as adopted), provider contracts and subcontracts shall include a statement that billing by and payment to the provider will be made in accordance with Labor Code §408.027. Carriers who fail to comply with Labor Code §408.027 are subject to administrative penalties under the Insurance Code and Labor Code, as applicable. Parties are free to negotiate penalty provisions in their contracts.

§10.42(c): Commenters request that the rules clarify that pay-for-performance standards may be adopted by networks without violating the prohibition in Insurance Code §1305.152(e)(related to prohibited financial incentives), in order to be consistent with HB 7, which tasks the commissioner of workers' compensation with promoting compliance with the workers' compensation system through performance-based incentives and developing performance-based oversight of carriers and providers through incentives. Another commenter suggests that language stating that provider

compliance with adopted treatment guidelines, return-to-work guidelines and individual treatment guidelines is not a violation of §10.42(c).

Agency Response: The department agrees that if pay-for-performance guidelines are adopted by the commissioner of workers' compensation that meet the requirements of Insurance Code §1305.152(e), then the guidelines would be allowed under §10.42(c). However, the department does not believe additional language is necessary to clarify this point. Section 10.42(c) specifies that 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 §10.42(c). Because providers are required to comply with adopted treatment guidelines, the provider does not violate §10.42(c) by following those treatment guidelines.

§10.42(d): A commenter supports §10.42(d), but requests additional language stating that either a general notification to providers or the addition of a provision in the network's contracts with providers stating that the network conducts economic profiling would satisfy the requirement to notify providers before the network conducts the profiling. The commenter also requests that the department change §10.42(d) to clarify that economic profiling restrictions relate only to the network application process and not to other medical payment data used in the claims process.

Agency Response: It is not necessary to add language relating to the economic profiling notice. Section 10.42(d) requires a carrier or network to provide written notice

to network providers prior to conducting economic profiling. The notice may be a provision added to provider contracts, or it may be a general notification to providers, as long as the network assures that each provider or group of providers receives the notice. The notice requirement related to economic profiling relates to individual profiling of a provider or provider group, rather than aggregate data that may be profiled. An example of such individual profiling is that of utilization management studies that compare the provider or provider groups to other providers. Neither Insurance Code Chapter 1305 nor these rules prohibit a provider from negotiating the provision of additional information as part of the contract with the network if the provider so desires.

§10.42(d): Commenters ask that the provision in §10.42(d) requiring a carrier or network to provide written notice to providers before conducting utilization management studies comparing the provider to other providers be deleted, due to the commenters' belief that the prior written notice would confound the results of what was intended to be an objective study of provider utilization management.

Agency Response: The department declines to remove the provision and agrees to remove the word “any” before “economic profiling” to clarify the carrier and network are not required to provide notice each time a study is to be performed. The carrier and network are only required to give a general notice to providers that economic profiling will be conducted, either at the time of contracting or at a subsequent date when profiling is instituted. Therefore, any skewing of results will be minimal. The reference

to utilization management studies is offered only as an example of a type of economic profiling and is not intended to be a limitation.

§10.42(d): Commenters support the proposed rule allowing networks to conduct economic profiling of providers under §10.42(d) and as allowed by the statute. Another commenter requests that the language in §10.42(d) be expanded to require that the network and carrier notify providers in advance of the contract with a more detailed explanation of the standards and methods used by a network in the course of economic profiling than is currently required by the proposed language which could allow for selective economic profiling, something that should not be allowed.

Agency Response: The department declines to add the requested language. If general notice of economic profiling is provided during the contracting process, the provider may ask for standards and criteria at any time or may negotiate a contract provision requiring such information to be given to the provider. If the notice is given after the provider has contracted with the network, the provider may request such information from the network. The rule language only requires that notice be given. It doesn't address the timing except for the fact that the notice must be prior to profiling. The department recognizes that economic profiling of providers is an integral part of managed care and believes that providers should receive notice prior to implementation of profiling. Insurance Code §1305.303(h) requires each network to implement a documented process for the selection and retention of contracted providers in accordance with the rules adopted by the commissioner. Accordingly, §10.42(d)

requires insurance carriers or networks to provide written notice to network providers before the carrier or network conducts economic profiling, including utilization management studies comparing the provider to other providers, or other profiling of the provider or group of providers. The department will monitor this issue.

§10.42(e): A commenter requests that patients be permitted to obtain durable medical equipment (DME) from any licensed pharmacy provider because workers' compensation pharmacy benefits are not required to be provided via a network, requests additional language indicating that DME providers are not required to contract with a network to participate in the workers' compensation system, and asks that the provision of DME through a pharmacy or pharmacy's agent be permissible.

Agency Response: The department disagrees because the provision of DME is not a pharmacy service. Insurance Code §1305.101(c) states that prescription medication or services as defined by Labor Code §401.011(19)(E) may not be delivered through a network. Insurance Code §1305.004(b)(4) defines "health care" by reference to Labor Code §401.011(19), which includes all reasonable and necessary medical aid, medical examinations, medical treatments, medical diagnoses, medical evaluations and services. Under Labor Code §401.011(19)(F) "a medical or surgical supply, appliance, brace, artificial member, or prosthesis . . . ." is included in the definition of "health care" but distinguished from prescription medication or services. Therefore, reasonable and necessary DME services can be network services. If a pharmacy is also a DME

provider, it may choose to contract with a network in that capacity, although not as a provider of pharmacy services.

§10.60: A commenter requests that §10.60 be amended to allow a carrier to act on behalf of an employer who fails to deliver the statutory notice of network requirements and acknowledgement form to their injured employees. The commenter further requests that a carrier be permitted to deliver the statutory notice via certified, return receipt mail and that the certified, return receipt mail signed by the injured employee be deemed to be the injured employee's acknowledgement of the receipt of the statutory notice of network requirements.

Agency Response: Under Insurance Code §1305.005 the employer is generally the party responsible for delivering the notice of network requirements to employees, including all the information required by §1305.451, and that it is the employer who is required to obtain a signed acknowledgment form from each employee, except in certain specified instances. Therefore, the department declines to make the requested changes. The department, however, is not aware of any provision that would prohibit the carrier from delivering the statutory notice of network requirements and acknowledgment form if the employer fails to take such action. The department disagrees that a signed receipt for certified mail can be deemed to be the employee's acknowledgment. The acknowledgment form contains certain information that must be provided to the employee and also requires the employee to provide certain information on the form, such as where the employee lives. A receipt for certified mail does not

meet this standard. Neither an employer nor a carrier is precluded from establishing a standardized process for delivery of the notice to include the use of certified or return receipt mail, but such process does not satisfy the requirement that signed acknowledgment forms be collected and maintained. Adopted §10.60 clarifies that when a carrier has an obligation to deliver the notice of network requirements and obtain the signed acknowledgment form, the carrier must also comply with the requirements of §10.60(c) - (h), as applicable.

§10.60: A commenter requests that the rules be changed to state that the carrier can delegate to the network the duty to deliver the notice through a network-carrier contract based upon provisions that require carriers to provide the notice. The commenter asserts that networks will be active participants in the development of the notice, so the process will be more efficient if the networks deliver the notice to participating employees.

Agency Response: Under Insurance Code §1305.005 the employer is generally the party responsible for delivering the notice of network requirements to employees, including all the information required by §1305.451, and that it is the employer who is required to obtain a signed acknowledgment form from each employee, except in certain specified instances. Therefore, the department declines to make the requested change. In those circumstances when a carrier may deliver the notice, such as in the event of the employer's failure to deliver the notice or in circumstances where the carrier is required to deliver the notice, such an employee who is injured prior to the effective

date of the Act, or prior to the employer's electing a network-limited plan, the carrier may delegate delivery requirements to a network. In such instances, the notice and mailing must clearly indicate that the notice is from the carrier and not the network.

§10.60: A commenter asserts that there are situations under the new workers' compensation law when a carrier, rather than an employer, is required to deliver the notice to employees. Insurance Code §1305.103(c) requires the carrier to provide notice to employees that are injured before the date that the carrier established or contracted with a network. Section 8.016 of the statute requires carriers to provide notice to employees injured before the effective date of the Act. The commenter recommends that §10.60 be amended to account for these scenarios.

Agency Response: The circumstances described in Insurance Code §1305.103(c) and Section 8.016 of HB 7 are addressed in the rule under §10.60(b). Section 10.60(b) applies to 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 a network, which includes employees who were injured before the effective date of the Act as well as employees injured after the effective date of the Act but before the employer or carrier established or contracted with a network. This subsection also addresses the carrier's obligation to provide a notice of network requirements and an acknowledgment form to these employees. The department recognizes that a carrier required to provide notice to employees under Insurance Code §1305.103(c) should obtain the signed acknowledgment form provided

to those employees. Accordingly, the department has added a provision to §10.60(f) to require carriers to obtain the employee acknowledgment form from these employees subject to Insurance Code §1305.103(c).

§§10.60 and 10.60(g)(14): A commenter requests that the information regarding providers that is required to be given to employees should also be given in electronic format because it can be updated daily. The commenter suggests providing one copy of the directory to be available at the employer's site, with electronic access available to all employees though the internet. Other commenters state that the rule does not include language that addresses how the network's list of healthcare providers is to be provided to an employee, and suggests addition of new provisions requiring provider directories to be published on a website with paper copies available upon request.

Agency Response: The department has made changes to the proposed rule to address the commenter's concerns. The department has added a provision in §10.60(c) to allow carriers and employers to deliver notices of network requirements in an electronic format, so long as a paper version of the notice is available upon request. This provision does not change the requirement that provider directories be updated at least quarterly. Additionally, a new provision has been added to §10.60(f) to allow the acknowledgment of receipt through electronic means.

§10.60(a): A commenter opines that some differentiation should be made for the different requirement for time of notice in Insurance Code §1305.005(d),(e) and (g).

Acknowledgement of prior notification should be sufficient for employee notice upon employer notice of an injury. In addition, the commenter believes that given that notice of injury may be given to the employer by a range of persons representing the employee, the rule should specify that network notice requirements may be provided to any person who may give notice to the employer of an injury on behalf of the injured employee. Another commenter recommends that §10.60(a) be modified to specify that a single acknowledgment is sufficient to bind employees to the network requirements. Another commenter asks that §10.60 be modified to permit the carrier to deliver the notice to staff leasing companies alone.

Agency Response: To avoid confusion regarding when an employee is to receive notice, the department has deleted references in §10.60(a) to the subsections (d), (e) and (g). With the deletion, the rule refers only to Insurance Code §1305.005, which requires that employees receive notice at the time of injury, as well as at other times. Notice to an employee at the time of injury is crucial and is specifically required by the statute. Therefore, network requirements are not applicable to an injured employee until notice is delivered to the injured employee by an employer that has received actual or constructive notice of the injury. Section 10.60(a) incorporates these provisions by reference. Any provisions in the Labor Code or related rules allowing any one of various persons representing the employee to give notice of injury to an employer would not override the Chapter 1305 requirements that the notice of network requirements be delivered to and the acknowledgment signed by the employee. In order to ensure that an injured employee has received notice of the network requirements, notice cannot be

given to an entity such as a staff leasing company. While the notice may be delivered through the staff leasing company, the acknowledgment must come from the individual employee.

§10.60(a): A commenter requests that any one documented instance of refusal should suffice to trigger Insurance Code §1305.005(f) and subject the refusing employee to the network requirements.

Agency Response: While the rules do not require multiple documented instances of refusal before subjecting the refusing employee to network requirements of the applicable network, it does not relieve the employer of its obligation to give a refusing employee a subsequent notice and a new acknowledgment form upon a change of insurance carrier or network.

§10.60(a)(1): A commenter strongly feels that the department should establish a specific time frame within which the employee is provided notice of network requirements. The commenter asserts that notice should be provided to the employee not more than one week or five working days after the date of employment. The commenter opines that setting a mandatory time line should significantly limit the number of employees who receive notice only after they are injured.

Agency Response: The department declines to add a specific time frame at this time because the rule incorporates by reference the statutory time frames. Section 10.60(a) requires carriers that establish or contract with networks to deliver to the employer, and

the employer shall deliver to employees in the manner and at the times prescribed by Insurance Code §1305.005. Insurance Code §1305.005(d) does not set forth any time frames for initial notice following establishment of the network. Subsection (e) requires employers to provide to employees hired after the notice is given under subsection (d) the required notice and information not later than the third day after the date of hire. Subsection (g) requires the employer to notify injured employees of the network requirements at the time the employer receives actual or constructive notice of an injury. Regarding concerns that the notice may not be provided timely, under the statute, an injured employee is entitled to seek care from any out-of-network providers prior to receipt of the notice.

§10.60(d): A commenter supports the creation of a sample acknowledgement form as referenced in §10.60(d) and requests the opportunity to submit input on the development and content of this standardized acknowledgement.

Agency Response: The commenter's support is appreciated, and the department has developed a sample acknowledgment form that will be available on its website. Pursuant to §10.60(d), a carrier and employer may use the sample acknowledgment form or the carrier and employer may develop and file an acknowledgment form that complies with the requirements of §10.60(c) – (e).

§10.60(e) and §10.60(e)(2)(C): A commenter requests that §10.60 be revised to fairly notify employees, in both the notice and acknowledgment form, of all the circumstances

when they may be liable for care. A commenter requests that the rule be revised to state that the employee may be liable for in-network care provided without a proper referral from a treating doctor because §10.60(e)(2)(C) only requires that the acknowledgment form notify an employee that the employee may be responsible for out-of-network care provided without network approval.

Agency Response: The department declines to make the suggested changes because the notice requirements in §10.60 incorporate all the circumstances when employees may be liable for care. Also, the hold harmless provision at Insurance Code §§1305.152(c)(1) and 1305.451(b)(6) does not specifically carve out the circumstance of the employee liability for in-network care provided without a proper referral from a treating doctor from its application.

§10.60(e)(2)(A) and §10.85(d): A commenter requests that the rules detail how carriers are to verify that an HMO provider is the injured workers' primary care physician.

Agency Response: It is the position of the department that carriers should be free to determine what method best suits their needs, and therefore, the department prefers not to prescribe how a network obtains such proof. The various methods by which a network could obtain proof that an HMO provider is the injured workers' primary care physician include HMO ID Cards, employee contact information, or employer verification.

§10.60(e)(2)(A)(iii): A commenter asks what defines an emergency and states that there must be a mechanism that the network or the employer must be contacted before the employee shows up at the emergency room on a weekend or after hours or anytime to avoid denial of charges.

Agency Response: The term “emergency” is defined pursuant to statute. Section 1305.004(a)(7) defines “emergency;” subsection (a)(13) defines “medical emergency;” and subsection (a)(15) defines “mental health emergency.” Sections 10.2(a)(7), (15) and (17) of the rule incorporate these definitions by reference. Section 10.102(a) provides that carriers and networks that use preauthorization processes within a network are to follow the requirements of Insurance Code §§1305.351-1305.355. Section 1305.351(c) states that “a network or an insurance carrier may not require preauthorization of treatments and services for a medical emergency.” Additionally, §1305.006 provides that an insurance carrier that establishes or contracts with a network is liable for out-of-network emergency care that is provided to an employee.

§10.60(f): A commenter asserts that insurance carriers and networks should be authorized to accept acknowledgment of notice requirements by electronic means and that requiring a signed, paper acknowledgment is unnecessary and wasteful. Another commenter requests that the rules clarify that an electronic signature would satisfy the requirement for employee signature on the acknowledgment form.

Agency Response: The department agrees and has made changes to the proposed rule to address the commenters' concerns. The department has added a provision to

§10.60(f) to clarify that acknowledgment of notice requirements may be accepted by electronic signature and by electronic means. The department understands the need to avoid waste. Even without the change, the rule would not prevent an employer or carrier from scanning or otherwise imaging copies of the signed acknowledgment forms and storing legible scanned or imaged copies by electronic, retrievable means.

§10.60(g): A commenter proposes a new paragraph to provide a transition period wherein certain employees who are already receiving treatment could continue treatment with a non-network provider for a period of time not to exceed one year. Such transition period would apply only to employees with an acute condition, a serious, chronic condition including chronic pain, a terminal illness, and to employees with authorized surgery or other procedure that is scheduled to occur within the next 180 days.

Agency Response: The department does not have the authority to make the requested change as it is contrary to statute. Insurance Code §1305.103(c) states that an employee who lives in 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, must select a network treating doctor upon notification by the carrier that health care services are being provided through the network. If the employee does not select a network treating doctor within 14 days after receiving a notice of network requirements, the network will assign the employee a treating doctor. Workers' compensation health care networks are required to provide

comprehensive and medically necessary care to treat a compensable injury. If a treatment or service is determined to be medically necessary, it must be provided. The statute provides no exceptions to this requirement.

§10.60(g): Another commenter also proposes a new paragraph in §10.60(g) to include a statement that the network must ensure that injured employees have reasonable access to surgically implanted, inserted, or otherwise applied devices or tissues and that the division shall periodically examine whether reasonable access exists.

Agency Response: The department declines to make the suggested change because the department does not agree that it is necessary to specify certain treatments or services that must be available, as all medically necessary care must be delivered to an injured employee.

§10.60(g)(6): A commenter requests clarification regarding who is going to be a treating doctor and why it appears that specialists such as orthopedic surgeons will not be treating doctors and will have to obtain referrals for visits.

Agency Response: Insurance Code §1305.103(a) provides that a network shall determine the specialty or specialties of doctors who may serve as treating doctors. Neither the rule nor Chapter 1305 prohibits networks from designating orthopedic surgeons as treating doctors or from designating them as both treating doctors and specialists in their provider directory.

§10.60(g): A commenter requests that the notice provisions set forth in §10.60(g)(5) - (8) be changed to more definitely establish that an employee will be liable for health care services in those circumstances. Additionally, the commenter requests a new paragraph (9) that would reference an employee's potential liability for health care services if the employee commits fraud in reference to the employee's address.

Agency Response: The department has changed the proposed rule in §10.60(g)(5) to address an employee's potential liability when the employee is found to live inside a network service area but to have received out-of-network services during the pendency of a dispute regarding where the employee lives. The department declines to make the other requested changes because it appears that the commenter is attempting to establish clear liability, when many other issues may also affect which party is ultimately liable.

§10.60(g) and §10.80(c): A commenter states that "specialist" as opposed to "treating doctor" may warrant definition because the rules allow the network to arrange for services including the referral to "specialists" while the worker may choose a treating doctor from the network's treating doctor list. The commenter asserts that "specialist" and "specialty" are terms used in a number of other contexts in the proposals and might generate confusion or disputes if not given the proper definition for the specific context.

Agency Response: The department does not agree that the term "specialist" needs to be defined and declines to make the suggested change. Generally, specialists are those other than treating doctors to whom treating doctors make referrals.

§10.60(g)(3): A commenter asserts that this provision requires that the employee be given detailed maps of the service area, including specified information contained in the subsection. The commenter states that this will result in bulky, difficult to read information that is expensive to produce and of limited value to employees and that this requirement should be deleted.

Agency Response: Employees need to be provided with maps of the area where they live, but there is no requirement that employees receive a map that is applicable only to areas outside of the area in which the employee lives. Therefore, limiting maps to a particular region may be appropriate. However, larger maps describing the entire service area must be available upon request. Additionally, employees are not subject to network requirements for regions not included in the notice.

§10.60(g)(4): A commenter opines that the department should establish a requirement that employees are provided notice of all pertinent information necessary for those who do not live within the network's service area.

Agency Response: The department does not agree that an additional notice requirement beyond those included in the statute is needed at this time but will monitor the issue and assess any need for future notice requirements. The adopted rules ensure that all employees receive notice of the network requirements, which will allow an employee living outside the service area to understand that the requirements are inapplicable.

§§10.60(g)(5) and 10.62(e): Commenters recommend that the rule require employees asserting that they live outside the service area to receive all care from network providers during the pendency of the insurance carrier's review of the employee's assertion or the department's review of the insurance carrier's decision. Another commenter suggests the same revision but would add that the rule should also expressly state that the employee will be liable for the care received out-of-network during the pendency of the appeal unless it is ultimately established that the employee lives outside the service area.

Agency Response: The department declines to make these changes because the presumption is that the employee is telling the truth about where the employee lives, and the truthful employee would be penalized by the requirement that this change would impose. Additionally, the suggested change could penalize employees who are unable to travel into the service area for treatment due to their injuries or those injured employees who require out-of-network care while living outside the network service area, such as those who require assistance with daily activities from caregivers. Additionally, the suggested changes are not consistent with Insurance Code §1305.451(b)(6), which provides that if the employee obtains health care from non-network providers without network approval, except as provided in §1305.006, the carrier may not be liable and the employee may be liable for payment for that health care.

§10.60(g)(5): A commenter states that §10.60(g) should be revised to fairly notify employees of all instances in which they may be liable for in-network or out-of-network care.

Agency Response: The statute and the rule address all contingencies of when an employee may be liable for in-network or out-of-network care. Insurance Code §§1305.152(c)(1) and 1305.154(c)(4), as well as §10.42(b)(1) of the rule, require provider contracts and subcontracts to include at a minimum a hold-harmless clause stating that the network and the network's contracted providers are prohibited from billing or attempting to collect any amounts from employees for health care services under any circumstances, including the insolvency of the insurance carrier or the network, except as provided by Insurance Code §1305.451(b)(6). Section 1305.451(b)(6) provides the only exception (when employee obtains health care from non-network providers without network approval, except as provided by §1305.006). The department has changed the proposed rule in §10.60(g)(5) to address an employee's potential liability when the employee is found to live inside a network service area but to have received out-of-network services during the pendency of a dispute regarding where the employee lives.

§10.60(g)(7): A commenter recommends removing "network or" because networks do not pay workers' compensation medical bills.

Agency Response: The department declines to make the suggested change because there is a statutory basis for this language. Insurance Code §1305.152(c)(1) requires

provider contracts and subcontracts to include a hold harmless clause stating that the network and network's contracted providers are prohibited from billing or attempting to collect any amounts from employees for health care services under any circumstances, including the insolvency of the insurance carrier or the network, except as provided by §1305.451(b)(6).

§10.60(g)(7): Commenters state that §10.60(g)(7) requires that the notice advise an employee of the "hold-harmless" protections and indicate that the employee will not be liable for any in-network care. Commenters respectfully request that the language be revised to clarify that the employee may be liable for payment for in-network healthcare services, if the employee did not follow the network requirements and obtain care either from the designated treating doctor or from a specialist, with appropriate referrals from the employee's treating doctor.

Agency Response: The department does not have the authority to make the requested revision. The statute is very resolute. Insurance Code §§1305.152(c)(1) and 1305.154(c)(4), as well as §10.42(b)(1) of the rule, require provider contracts and subcontracts to include at a minimum a hold harmless clause stating that the network and the network's contracted providers are prohibited from billing or attempting to collect any amounts from employees for health care services under any circumstances, including the insolvency of the insurance carrier or the network, except as provided by Insurance Code §1305.451(b)(6). Section 1305.451(b)(6) provides the only exception

(when employee obtains health care from non-network providers without network approval, except as provided by §1305.006).

§10.60(g)(12)(B): A commenter expresses an opinion that the deadline for filing complaints should be no less than 180 days after the date of the event or occurrence. If the complaint is regarding a utilization review, then, by definition, the time to get an independent review organization decision may be more than the 90 days.

Agency Response: Insurance Code Chapter 1305 and the rule do not establish a deadline for filing complaints. Insurance Code §1305.401(b) allows the network the option to set a 90-day deadline for filing complaints beginning with the date of the event or occurrence that is the basis for the complaint. Therefore, the network may elect to set a longer time period for the deadline. Section 10.60(g)(12)(B) requires that the notice of network requirements disclose whether the network has opted to establish a deadline. In addition, the statutory definition of complaint states at Insurance Code §1305.004(a)(5)(B) that a complaint does not include an oral or written expression of dissatisfaction or disagreement with an adverse determination. Utilization review complaint and appeal deadlines are addressed in Subchapter F of the rule.

§10.60(g)(12)(C): A commenter states that a single point of contact within the network is good in concept, but there must be a backup system when this point of contact is not available.

Agency Response: The department does not agree because the single point of contact may be a customer service unit or other unit, so that there would be more than one person involved in handling the complaint intake process.

§10.60(g)(14): A commenter requests that the section be amended to require the network to update its list of contract providers every 30 days for web-based listings and every 90 days for print based listings.

Agency Response: The department declines to make the suggested change because the rule mirrors the statutory language in Insurance Code §1305.451(b)(12). However, if the network chooses, it can update the provider lists more often.

§10.60(g)(14): A commenter states that given that most employees will not incur a compensable injury, the at-least quarterly requirement must not be construed so as to require that every employee receive a quarterly directory, which would be cost prohibitive. The commenter suggests that language should indicate that every employee have access to a list through their employer or through a website.

Agency Response: The rule does not require that employees be given a provider directory quarterly. Section 10.60(a) provides that 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 a notice of network requirements and employee information which includes the provider directory that is a current directory. A provider directory is current

if it is updated at least quarterly. Section 1305.005(g) requires notice at the time the employer receives actual or constructive notice of an injury. Section 1305.005(d) requires employers give all employees the notice of network requirements and to post notice of network requirements at each place of employment. Section 1305.005(e) requires notice at the time the employee is hired.

§10.60(g)(14)(A): Commenters recommend deleting the requirement in §10.60(g)(14) that the list of network providers included in the notice must clearly identify the providers who are authorized to assess maximum medical improvement and render impairment ratings. The commenters state that this requirement is unnecessary because treating doctors sometimes refer patients out of network for assessments, and the employee will not understand the terminology and the assessments will occur whether or not the authorized providers are identified.

Agency Response: The department declines to make the requested change because the information is needed for other purposes. The information contained in the provider directory is also needed by network doctors who may wish to refer their patient to a network provider to assess maximum medical improvement (MMI) and impairment ratings (IR).

§10.60(g)(14)(A): A commenter requests that, to assure consistency within the system, the department define the term "treating doctor" and show the criteria used to draft the definition.

Agency Response: The term "treating doctor" is defined in the rule. Section §10.2(b)(13) and Insurance Code §1305.004(b)(10) incorporate the definition of “treating doctor” by reference to Labor Code §401.011(42), which defines “treating doctor” as “the doctor who is primarily responsible for the employee’s health care for an injury.” Because the definition is a statutory definition, the department does have information on the criteria used to write the definition.

§10.60(g)(14)(A): A commenter states that it would be advantageous for a network to have the flexibility to list the same doctor on both the treating doctor list and the specialist doctor list and requests that the rule be revised to reflect such.

Agency Response: The networks have the flexibility to list the same doctor on both the treating doctor list and the specialist doctor list if the doctor indeed meets both descriptions under the current rule language.

§10.60(g)(15): A commenter asserts that allowing 21 days for a network to arrange for services including referrals to specialists, is too much time for an injured employee and requests that the time be limited to 72 hours. The commenter states that 21 days is too long to wait to get an injured worker treatment. The commenter asserts that to reduce medical costs, getting the injured worker to the providers quickly and back to work quickly should be the focus and that this time period should be 5 - 10 days maximum. Another commenter feels that referrals to specialists should not be denied. The commenter indicates that certain conditions, when left untreated, become chronic and

potentially permanent. The commenter asserts that the initial visit, at a minimum, should be allowed and paid for; however, subsequent visits should be subject to preauthorization. A commenter feels 21 days is too long to wait for referral to specialists and such delay could increase the amount of needed care (e.g., necessitate additional surgery).

Agency Response: Under Insurance Code §1305.302(f), the statutory requirement for referrals for care (except emergencies) is: "… to be accessible to employees on a timely basis on request, but not later than the last day of the third week after the date of the request." Although the rule currently mirrors the statute, the department recognizes that circumstances may sometimes warrant services being provided sooner. Therefore, the department has changed the provision to clarify that the referral should be made within the time appropriate to the circumstances and condition of the injured employee but not later than 21 days after the date of the request. Under the statute, a treating doctor's referrals to an in-network specialist do not require approval by the network. Although out-of-network referrals require approval by the network, they must be allowed where appropriate. It is the department's position that when circumstances warrant, care must be provided quickly, and that should guide the network in its referral process.

§10.60(h): A commenter states that §10.60(h) requires employers to deliver a notice and acknowledgement for a "network that has a service area in which the employee lives." A commenter asserts that it is unclear how to determine if the employer has sent the appropriate network notice. The commenter notes that §10.60(h) provides that

failure of an employer to establish a standardized process for delivering the notice creates a rebuttable presumption that the employee has not received the notice. The commenter states that this should be reversed to state that if an employer establishes a standardized process, documentation of that process should create a rebuttable presumption that notice was received. Another commenter also requests deletion of the phrase “for a network that has a service area in which the employee lives” because the responsibility of the employer is to ensure that the notice is delivered and that the service area be identified; the employee’s residence is secondary in this situation.

Another commenter states that there is no requirement in Insurance Code Chapter 1305 that the employer establish a "standardized process of delivery." As long as there is credible documentation that the employer (or carrier) delivered notice of the network requirements to the employee then the employee should be subject to the network requirements. Otherwise, there will be cases in which the Division could rule that an employee is not required to get medical care within the network despite the fact that the employee was notified of the network requirements on the grounds that the employer had failed to "establish a standardized process of delivery." The commenter posits that this could lead to many disputes in which notified employees try to escape network coverage by challenging whether or not the employer has an established standard process of delivery.

Agency Response: The department declines to make the suggested change because the requested change appears to subject an employee to network requirements even though a notice for the appropriate network was not actually provided. In addition, the

consequence of failing to establish a standardized process will prompt an employer to establish such a process. The rules do not require an employer to establish a standardized process of delivery. An employer's or carrier's failure to establish a standardized process as set forth in §10.60(h) creates a rebuttable presumption that the notice was not received by the employee. The department has changed §10.60(h) to require documentation of the location of delivery, method of delivery, and to whom the notice was delivered.

§10.60(h): A commenter states that the rule offers inadequate protections to carriers if employers are lax in distributing the notice of network requirements. The commenter recommends revising §10.60(h) to require that employers deliver the notice and acknowledgment form to employees within 5 - 7 business days of signing the network plan contract or at least 30 days prior to the effective date of coverage and for new employees within two business days after their first date of employment.

Agency Response: The department declines to make the requested change. Section 1305.005(d) states that the insurance carrier shall provide the notice to the employer for delivery to employees but does not impose a time requirement on either party. The department declines to impose such a requirement on an employer without express statutory direction. In addition the department does not have the authority to require that notice to new employees be delivered within two business days of the first date of employment because §1305.005(e) requires notice delivery to new employees no later than the third day after the date of hire. It appears that an employer would have an

interest in delivering the notice promptly in order to reduce the employer's cost-of-claim experience.

§10.60(h): A commenter requests that §10.60(h) be revised to state that if the employer fails to deliver or to maintain documentation of delivery of the notice of network requirements, the carrier has the right to adjust the employer's premium to reflect the fact that some or all of the employees will not be subject to previously agreed upon network requirements.

Agency Response: The department declines to make the change. If the carrier's policy or any endorsements to the policy call for a premium adjustment under these circumstances, the rules would not prohibit the carrier from adjusting the employer's premium. Also, if a contracting party has not performed as agreed to the detriment of the other contracting party, there may be other avenues available for the damaged party to seek redress. This includes delivery of notices by the carrier if the employer fails to do so.

§10.60(h): A commenter observes that the rule does not state whether the employee must live in the service area at the time the notice is delivered and recorded or at the time the employee is injured in order for it to be assumed whether the notice is delivered.

Agency Response: An employer must deliver a notice that applies to the employee's address in order for the network requirement to apply to the employee. This will be

most important at the time of injury, as the injured employee should be given notice that is specific to the employee's address at the time of the injury.

§10.60(i): A commenter states that Labor Code §408.0271 requires carriers to notify only health care providers within a network of a non-compensability determination. The commenter suggests a change to include in the rule a method for a pharmacy to check on the status of a patient's claim for services. Such pharmacy access could be through a secure online website or telephone conference. According to the commenter, notice must be made available to pharmacists within a reasonable time period. The commenter recommends that the carrier be liable for all pharmacy services provided until the notice was made available to pharmacies. The commenter proposes that pharmacies be responsible for checking an injured employee's compensability status and for services provided after the date the notice was made available.

Agency Response: Insurance Code §1305.101(c) provides that prescription medication or services may not be delivered through a workers' compensation health care network but shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation. Therefore, the proposed rule does not address the concept of notice being given to non-network pharmacists. The department will monitor this issue for possible future rulemaking.

§10.61: A commenter requests a definition for "network service area" because the lack of a definition allows the opportunity for abuse of the system.

Agency Response: The rule and Insurance Code §1305.004(a)(24) define service area as a geographic area within which health care services from network providers are available and accessible to employees who live within that geographic area.

§10.61(e): Several commenters recommend that, if an employee has committed fraud, the language "may be liable for payment for that health care" be changed to "will be liable ...." to send a very clear message that fraud will not be tolerated and that there are consequences for doing so. The commenters state that failure to do so may create problems. Another commenter states that providers who give healthcare treatment and services to injured employees who have fraudulently misrepresented where they live should not be unfairly penalized by a law with no teeth. Another commenter requests amendment by adding that, at the insurance carrier's discretion, the employee shall be liable for payment of the difference between what the carrier paid to the non-network provider and what the insurance carrier would have paid for the same service if a network provider had rendered it.

Agency Response: The department declines to make the specific change to add language stating that the employee “will be liable” because the employees' liability turns on a number of contingencies such as being able to prove an injured employee “fraudulently claimed to live outside the network’s service area. . . .” The department agrees that fraud should not be tolerated. However, the requested change does not necessarily provide an effective countermeasure to possible fraud, but does attempt to add a conclusory statement regarding liability to the rule. The department declines to

make the requested change concerning the insurance carrier's option to charge a balance to the employee as it could encourage or provide an out-of-network option for employees that is not contemplated by the statute.

§10.61(f): A commenter supports section §10.61(f), which clarifies a carrier's liability for payment of out-of-network services and the available remedies if a network denies a referral request. However, the commenter recommends that the department adopt a definition for "emergency care." Although the proposed rules define "emergency" as "either a medical or mental health emergency," these definitions do not address the scope of services that constitute "emergency care," nor do they adopt the prudent layperson standard applicable to HMOs. Because workers' compensation health care networks closely resemble HMO products, the commenter suggests the inclusion of the definition "emergency care" for HMOs set forth in Texas Insurance Code §843.002(7).

Agency Response: The department declines to make the recommended change because the definition of "medical emergency" in §10.2(a)(15), which mirrors the language in the statute at Insurance Code §1305.004(15), is sufficient.

§10.61(f): A commenter raises concerns that the rules do not address the possibility that a network doctor may not be available at the time of injury, whether because the network has lost or failed to add a sufficient number of providers or because a network doctor who treats the specific injury is not taking new patients. If networks are to be designed so that employees receive adequate care and are able to return to work as

soon as possible, the commenter believes the rules should specify that employees may receive care from out-of-network doctors if no network doctor is available. The commenter maintains that although the department presumably would take administrative action against the network, the injured employee could require more immediate medical care, including out-of-network care. The commenter recommends adding language that specifically provides for an employee's ability to go to an out-of-network provider in such a circumstance.

Agency Response: The department declines to make the change. Networks are required to have adequate numbers of treating providers available to injured employees. If a significant number of providers leave the network, the network is required to notify the department through a modification of network configuration filing under §10.27. The department will then be able to require that necessary providers be available whether through a filed access plan or some other similar mechanism. As far as the availability of a specific network provider, treating doctors are required to have coverage 24 hours a day seven days a week. In some situations, such as if a doctor is on vacation the doctor may make arrangements for another doctor to substitute as necessary. If a doctor leaves a network, the employee will need to choose another treating doctor.

§10.61(f)(2): A commenter expresses concerns with the provision that specifies that an insurance carrier is liable for "healthcare provided to an injured employee who does not live within the service area of <u>any</u> network established by the insurance carrier or with which the insurance carrier has a contract." The commenter is concerned with the

inclusion of the word "any" before network and the commenter states that the rules need to specify that the network established by the insurance carrier must be that which has been contracted for by that employee's employer. According to the commenter, that is the only way that the notice requirements can be met by the employer and the carrier as well; this could present a potential conflict if not clarified before final adoption.

Agency Response: This provision tracks the language in Insurance Code §1305.006(2), which states that carriers are liable for out-of-network health care that is 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. This language does not require that an employer deliver notice of a network or service area for which the employer did not contract. Additionally, an employee is not liable for out-of-network health care if the employee has not received an appropriate notice of network requirements in accordance with §1305.005 that is applicable to the network for which the employer has contracted and the area in which the employee lives.

§10.61(f)(3)(A): One commenter recommends that this section be changed to provide that a network must approve or deny a referral by a network treating doctor to an out-of-network provider "for medically necessary services that are not available from network providers" within not more than three days rather than the seven days provided in the rule. The commenter believes that seven days is too long a period to address such a referral.

Agency Response: The department agrees that seven days may be too long to wait for a referral in some instances. Accordingly, the language in §10.61(f)(3)(A) requires the network to approve or deny a referral to an out of network provider "within the time appropriate under the circumstances but, under any circumstances, not later than seven days after the date the referral is requested."

§10.61(f)(4): A commenter requests that §10.61(f)(4) be revised to delete "appropriate" and reference only subsection (a) of §10.60.

Agency Response: The department declines to make the suggested change to delete the word "appropriate." Section 10.61(f)(4) addresses the employee who received a notice of network requirements that does not apply to the service area where the employee lives. The carrier is responsible for care provided before the employee receives the notice of network requirement for the appropriate network and service area. The department has made a clarifying change to proposed §10.61(f)(4) by adding "and service area" after "appropriate network" to further clarify that an employee must receive a notice that specifically applies to the employee and where the employee lives. Regarding the suggestion that subsection (a) be added to the reference in the provision to §10.60, the department declines to add this specific reference because the duty to deliver the notice to previously injured employees is addressed in subsection (b) of that section.

§10.62: A commenter observes that the dispute resolution process is pretty successful in commercial health and thinks that the networks are reporting all their dispute resolutions and outcomes as required. The commenter suggests that the department should monitor how the dispute resolutions are working.

Agency Response: The department appreciates the comment. The department currently monitors the dispute resolution processes for HMOs on a routine basis, and for other types of carriers on a case-by-case basis.

§10.62: A commenter states that the proposed rule does not require the employee's request for review to be in writing, although it does require the injured employee to provide the insurance carrier with supporting evidence. The commenter recommends that the rule be amended to provide that an employee must submit its request to the insurance carrier in writing and that the request must be accompanied by evidence that supports the employee's assertion.

Agency Response: The department declines to make the proposed change because an employee may not be able to make a written request for review. Also, the commenter's concern is addressed by the fact that the additional evidence submitted to the carrier will provide documentation of the request.

§10.62: A commenter requests that the department ensure that hospitals not be penalized in the event of a dispute over where the employee lives.

Agency Response: The rules contemplate that all providers are similarly situated and will be similarly affected in the event of a dispute regarding where an employee lives. The department has modified the contents of notice of network requirements in §10.60(g)(5) to include notice to an employee at time of injury that the employee may be liable for out-of-network care received during the pendency of a dispute regarding where the employee lives. The department does not have the authority to ensure by rule that hospitals are not penalized in the event of a dispute over where an employee lives. A hospital may take needed measures to ensure that the hospital gets paid in accordance with federal and state law.

§10.62(b): A commenter states that the alternative service area provision is double jeopardy because the carrier can issue a service area map, determining in and outside the network service area, but still require an employee to participate in an alternate network. According to the commenter, employees should not be subject to an alternate service area.

Agency Response: The requirement to participate in an alternate service area is based on the statutory requirement in Insurance Code §1305.006, which provides that the carrier is responsible for health care provided to an injured employee who does not live within the service area of any network established by or contracted with the insurance carrier. Any and all networks and service areas may be considered to determine whether the employee lives in a network's service area, but network requirements will not apply until the employee receives the appropriate notice that

applies to the correct network or service area. An employee may not be held liable for care received outside the alternate network unless the employee has received notice of network requirements for the alternate network.

§10.62(b): One commenter opines that in some cases, it may be acceptable and preferable for an employee to receive services within an alternate service area, but the rule should take into account whether the employer has contracted with the carrier for the alternate service area. According to the commenter, a carrier should not be required in every instance to allow employees to access alternate service areas of the network. Accordingly, the commenter requests that this rule be revised to provide that the employee may receive services in the alternate service area if the carrier and the employee agree to this arrangement, which is consistent with §10.61(d).

Agency Response: The department declines to make the requested change because the ability to access an alternate service area will depend upon the language in the contract issued to the employer. If the employer purchased access to a network that includes more than one service area, then more than one service area will be available. If the employer did not purchase access to any and all of a particular network's service areas, that will control the determination of whether an alternate service area applies.

§10.62(b): A commenter asserts that the proposed rules are unclear and seem to conflict with regard to employees who are temporarily or permanently outside the original network's service area but within a service area of another network established

by or contracted with the applicable carrier. The commenter states that §10.62(b) indicates that an alternate service area employee is required to receive services within the alternate service area of a network contracted with or established by the carrier upon receipt of a notice from the carrier by selecting a treating doctor in the alternate service area. The commenter opines that §10.61(d) suggests that an alternate service area employee may choose to receive services within the alternate service area of a network contracted with or established by the carrier by stating that an employee who does not live within the original 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." Carriers, however, are not generally liable for out-of-network care provided to alternate service area employees (excepting emergency care and necessary referrals). Under §10.61(f)), which tracks Insurance Code §1305.006, the commenter believes that a carrier is only liable for out-of-network care provided to employees who live outside the "service area of any network" established by or contracted with the carrier. Because alternate service area employees do live within a service area of a network established by or contracted with the carrier, the commenter asserts that the carrier's liability seems to be limited to "in-network" care for alternate service area employees (although in this context, "in-network" would arguably include providers in the service area of the original network or the alternate service area in which the alternate service area employee lives).

Agency Response: Network requirements do not apply to a particular employee if: (1) the employee lives outside the service area; or (2) the employee has not received

appropriate notice of the applicable network. An employee who does not live within a network service area may seek out-of-network care. This is true without regard to the circumstances that establish where the employee lives (e.g., temporary assignment, travel). Similarly, an employee who has received the appropriate notice of network requirements must generally seek services inside the network. This is also true without regard for an employee's individual circumstances that may affect where the employee lives. The basic requirement of the rules and statute is that the employee must receive notice of any network that a carrier wishes to apply to the employee.

§10.62(c): A commenter states that the proposed rule requires the insurance carrier to notify the employee, in writing, of the carrier's determination no later than seven calendar days after the date the insurance carrier receives notice of the employee's request for review. The commenter indicates that seven calendar days is not an adequate amount of time. Commenters request that the proposed rule be amended to provide that an insurance carrier must notify the employee, in writing, of the carrier's determination within ten business days of receiving the employee's request for review.

Agency Response: The department declines to make the requested change because the department believes that seven calendar days is a sufficient amount of time for a carrier to review the employee's evidence and make its determination. It is important that all injured employees have timely access to health care services. An injured employee who asserts that he or she does not live in the network service area is entitled

to a prompt resolution of the dispute so the employee will know if out-of-network care will be covered.

§10.62(e): A commenter states that if an employee disputes whether he or she lives within the network and that employee is driving to and from a network area every day, it is not overly burdensome if the employee disputes whether the employee lives within the network to require them to receive their care in the network until that dispute is cleared up.

Agency Response: Section 10.62(e) permits an employee who disputes whether he or she lives within a network's service area to seek all care from the network during the pendency of the carrier's review and the department's investigation of a complaint. The department declines to make this change because the presumption is that the employee is telling the truth about where he or she lives, and the truthful employee would be penalized by the requirement that this change would impose. Additionally, the suggested change could penalize the employee who is unable to travel into the service area for treatment due to his or her injuries or those injured employees who require out-of-network care while living outside the network service area, such as those who require assistance with daily activities from caregivers. The department has changed the proposed rule in §10.60(g)(5) to provide that an employee who is receiving care from out-of-network providers during the dispute process may be liable for payment for health care services received out of network if it is ultimately determined that the employee lives in the network's service area.

§10.63(b): A commenter requests clarification as to whether this certification must be submitted only with the copies of the notice of network requirements and employee information forms that are filed with the department for approval or whether the certification must be distributed to every employee enrolled in a network plan. Given the content of the certification, a commenter encourages the department to require filing of the certification with the department only.

Agency Response: The department agrees that clarification is needed and has changed the proposed rule to clarify that the certification must be filed with the department.

§10.80: A commenter recommends that a new subsection be added to establish minimum acceptable standards for in-network utilization in a service area. The commenter states that minimum acceptable standards could be established using historical patient encounter data and that failure by a network to meet these acceptable standards of network utilization should result in the mandatory submission of a corrective plan of action for that area. The commenter also recommends that if a network continues to fall below acceptable utilization standards for a six month period, the network should be required to pay prevailing charges for the delivery of all out-of-network services. Finally, the commenter proposes that continued failure to meet acceptable utilization standards should result in termination of the network in that service area by the department.

Agency Response: The department declines to revise the proposed rule to add the suggested requirements. Such revisions would substantively change the rule late in the rulemaking process, which would circumvent the protections afforded by Government Code §2001.029 and require the republication of the rule with another 30-day comment period before the rule could the considered for adoption. The department will monitor the issue for possible future rulemaking.

§10.80(a): A commenter commends the requirement that all services specified by §10.80(a) must be provided by a provider who holds a current appropriate license.

Agency Response: The department appreciates the support.

§10.80(b): One commenter opines that services billed as physical or occupational therapy must be provided by therapists licensed by the State of Texas and that chiropractic services should not be billed as occupational or physical therapy. If therapy is provided by a non-licensed occupational or physical therapist, the commenter urges that it be coded differently so that separate studies on cost and outcomes can be made by the network.

Agency Response: Insurance Code §1305.153(d) requires that billing by contracted providers will be subject to the requirements of the Texas Workers' Compensation Act and applicable rules as consistent with this chapter. Insurance Code §1305.302(a) requires that all services specified in the section be provided by a provider who holds an appropriate license, unless the provider is exempt from license requirements.

Insurance Code §1305.302(d) requires that physical and occupational therapy services and chiropractic services be available and accessible within the network's service area. The Texas Workers' Compensation Act under Labor Code §413.011(a) requires that reimbursement procedures must be in accordance with the Centers for Medicare and Medicaid Services (CMS) requirements. Therefore, the department anticipates that billing codes utilized by providers will be consistent with those requirements.

§10.80(b): Commenters request clarification of what will constitute an adequate network and what is a sufficient number of providers. Another commenter requests that the same criterion, ratio of providers to population, be applied to all health care providers and that all criteria be standardized by the department. The commenter further requests that the department set the ratio of providers to population to assure that providers are available and accessible to injured workers 24 hours a day, seven days a week, within the networks' service area, as stated in the rule.

Agency Response: The department will use historical utilization data and demographics to evaluate the network adequacy of applicants. As networks begin to provide care, the department will monitor complaints received by the network and through the department, as well as quality improvement studies by networks, to evaluate network adequacy on an on-going basis. The department declines to impose a more rigid standard which fails to promote flexibility to consider the discrete requirements of a particular service area.

§10.80(b): Commenters request clarification in the rule or in the preamble to the adoption of the rules that the rule and the statute do not require that all of the treating doctors and specialists in the network be available 24 hours per day and seven days per week, but that rather an adequate number of treating doctors and specialists from the network provider panel need to be available to render care 24 hours per day and seven days per week. Commenters suggest that the rule be modified to indicate that access to an urgent care or emergency care center during the treating doctor's and network specialists' non-business hours and days satisfies the accessibility requirement.

Agency Response: The department does not have the authority to make the requested change because §1305.302(b) requires that all treating doctors and specialists in the network be available 24 hours per day, seven days per week. Section 1305.302(b) provides that 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. Availability may be established by telephone answering service, pager, or directly by telephone. The provider may direct employees to urgent care centers or emergency rooms if the provider judges such sites to be the appropriate location for care. Networks will be expected to monitor after-hours availability of providers as part of their quality improvement program and take action if providers are not available.

§10.80(b): Some commenters voice concern that there are no exceptions in the rule to address situations wherein a specific type of provider is unavailable and to allow for referrals to out of network providers.

Agency Response: Section 10.80(f) addresses situations wherein a specific type of provider is unavailable by requiring networks to include an access plan as set forth in Insurance Code §1305.302(h). Referrals to out-of-network providers are allowed. Insurance Code §1305.103(e) requires that a treating doctor provide health care to the employee for the employee's compensable injury and make referrals to other network providers, or request referrals to out-of-network providers, if medically necessary services are not available within the network.

§10.80(b)(2): A commenter suggests amending §10.80(b)(2) to require that the network's provider panel include sufficient numbers and types of health care providers to ensure choice, access, and quality of care to injured employees for all medically necessary covered treatments and therapies. The commenter also requests that a provision be added to require that, given the small subset of anesthesiologists and neurosurgeons that perform chronic pain implants, as well as the small group of neurosurgeons and orthopedic surgeons with specialization in spinal surgery, the network provider panel must include doctors who are qualified and willing to provide spinal surgery, which doctors are qualified and willing to provide chronic pain therapies, including but not limited to, the implantation of neurostimulators and intrathecal drug pumps that meet the access standards put forth in §10.80.

Agency Response: The department does not agree that the requested change is needed. If spinal surgery and chronic pain therapies such as implantation of neurostimulators and intrathecal drug pumps are determined to be reasonably necessary to treat injured workers, then they must be provided and the department expects that they will be provided. Pursuant to Labor Code §408.021(a), an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Insurance Code §1305.004(b) incorporates by reference the definition of "health care" in Labor Code §401.011(19), which specifies that a reasonable and necessary medical or surgical appliance is included in the term.

§§10.80(b)(5) 10.80(d): Commenters recommend decreasing the mileage limitations defining adequate accessibility because they believe that 30 miles and 75 miles are too far for injured workers, particularly physical and occupational therapy patients, to travel to receive care.

Agency Response: The department does not have the authority to change the distance requirements because they are statutorily mandated in Insurance Code §1305.302(g).

§10.80(b)(7): Commenters recommend changing §10.80(b)(7) to require only that the network's provider panel must include an adequate number of doctors, rather than treating doctors, who are qualified to provide maximum medical improvement and

impairment rating services. One commenter states that there is no reason that maximum medical improvement and impairment rating services must be performed by a treating doctor and indicates that many ratings are done on a referral basis.

Agency Response: The department agrees that referral providers may provide maximum medical improvement and impairment rating services and has changed the rule accordingly.

§10.80(c): Commenters believe 21 days is too much time to get injured workers in to see providers.

Agency Response: Consistent with Insurance Code §1305.302(f), the rule requires a network to 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. Section 10.80(c) contemplates that networks will arrange care according to timelines appropriate to the injured workers' circumstances and condition.

§§10.80, 10.22, 10.41. 10.42, and 10.60: A commenter states that the proposed rules address access to doctors and facilities but do not specifically address access to certain therapies such as those for chronic pain. The commenter requests that additional language be added to the rule that (i) requires reimbursement rates be sufficient to ensure reasonable access to surgically implanted, inserted, or otherwise applied devices or tissues; (ii) indicates which doctors will implant neurostimulators and

intrathecal drug pumps; (iii) requires a network to ensure that injured employees have reasonable access to surgically implanted, inserted, or otherwise applied devices or tissues; (iv) states that the Division shall periodically examine whether reasonable access exists; and (v) requires information concerning doctors who are qualified and willing to provide spinal surgery, and which doctors are qualified and willing to provide chronic pain therapies, including but not limited to, the implantation of neurostimulators and intrathecal drug pumps.

Agency Response: The department does not agree that the requested changes are needed. If spinal surgery and chronic pain therapies such as implantation of neurostimulators and intrathecal drug pumps are determined to be reasonably necessary to treat injured workers, then they must be provided and the department expects that they will be provided. Insurance Code §1305.103(e) requires that a treating doctor provide health care to the employee for the employee's compensable injury and make referrals to other network providers, or request referrals to out-of-network providers if medically necessary services are not available within the network. Pursuant to Labor Code §408.021(a), an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Insurance Code §1305.004(b) incorporates by reference the definition of "health care" in Labor Code §401.011(19), which specifies that a reasonable and necessary medical or surgical appliance is included in the term.

§10.80(g)(4)(C): A commenter states that §10.80(g)(4)(c) requires a network access plan to include a description of 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. If the services are unavailable or inaccessible, the commenter inquires as to what type of plan would assure availability and accessibility.

Agency Response: The network is required to show that it has sufficient contracted providers within its service area to provide comprehensive health care services to injured workers. The network is also required to identify areas in which it does not have adequate contracted providers and to submit an access plan for how it will provide the necessary services that are not available through contract. For example, an access plan may include a provision that employees may obtain service from a non-contracted provider. The department expects the network to indicate how the services will be provided to the employee.

§10.80(i): A commenter states that networks should be required to expand services outside the network's service area to accommodate employees who live outside the service area.

Agency Response: Insurance Code §1305.302(j) states that the network is not required to expand services outside the service area to accommodate employees who live outside the service area. However, the network may elect to obtain a contract with

providers outside the service area for injured employees who live outside the service area due to temporary assignment or who are staying with a caretaker outside the services area in order to facilitate cost-effective care, if the employee agrees. Such an employee, however, may alternatively choose to seek care from non-network providers at his option.

§10.81: Commenters raise concerns about the lack of a requirement that networks coordinate their case management activities with the insurer and that case management efforts may be duplicated. Commenters also raise concerns about the over-utilization of case management and resulting unnecessary costs. A commenter requests a phase-in of the requirement that all case managers be certified provided a certified case manager supervises non-certified case managers to provide non-certified case managers with the opportunity to prepare for and take one of the bi-annual examinations. Another commenter states that credentialing raises the quality of the case manager to a higher standard and believes that there will be a resultant enhanced expertise to develop return-to-work planning and address the overall cost-effectiveness of evidence-based treatment outcomes. Another commenter suggests that there are several evidence-based guidelines which make reference to the delivery of case management triage under which each ICD-9 code condition uses algorithms applied to data to label each condition with priority indicators, which in turn help determine the appropriate level of case management required for the individual. The case management levels vary based on the severity of the injury, but, the commenter asserts that the timeframe from which

an injury should be referred to case management should be carefully considered for optimum results. According to the commenter, by following these guidelines and establishing specific criteria within the networks for case management intervention, over-utilization of case management would be limited. Other commenters recommended specific certification requirements for inclusion in the rule.

Agency Response: Networks and carriers may agree by contract to procedures that will eliminate duplication of effort and ensure coordination between the case management programs of the two parties. The department agrees that a phase-in approach to achieving networks that have all of the case managers certified appropriately is beneficial and will allow non-certified case managers to take the necessary examinations. During the phase-in period, non-certified case managers must be supervised by certified case managers in order to assure the quality of the case management functions. The department has revised proposed §10.81 accordingly.

§10.81: A commenter states that the requirements related to quality improvement programs are too intense and believes the network should be able to delegate some of the requirements to the carrier.

Agency Response: The quality improvement requirements are derived from Insurance Code §1305.303. Networks may delegate credentialing to a qualified entity as set forth in Insurance Code §§1305.102(c)(3) and 1305.154(c)(2) and (10).

§10.81: A commenter opines that the language of the rule should support that each major provider type is represented on the quality improvement committee.

Agency Response: The department recognizes that participation by a broad sample of providers on the quality improvement committee is a desirable goal. However, to add a requirement that each major provider type be represented on the committee would be a substantive change late in the rulemaking process, which would circumvent the protections afforded by Government Code §2001.029 and require republication of the rule with another 30-day comment period before the rule could be considered for adoption. The department will monitor the issue for possible future rulemaking.

§10.81(a): A commenter asserts that quality improvement program procedures, processes and implementation should be available upon request pursuant to the Open Meetings Open Records Act and requests that a Doctor of Chiropractic should be appointed to each quality improvement committee.

Agency Response: Any requests to the department for filed information will be addressed in conformance with the Open Records Act. The statute requires that the quality improvement committee shall include network providers, and Doctors of Chiropractic will therefore be eligible for appointment to the committee by the governing body.

§10.81(b)(2): A commenter states that the scope of requirements for inclusion in the quality improvement work plan under §10.81(b)(2) is overbroad and excessive, creating

mandates for networks based on information that is held by carriers rather than networks. For example, according to the commenter, the development of a work plan reflecting types of services and the population served in terms of age groups, disease or injury categories, and special risk status, such as type of injury is outside the purview of network operations.

Agency Response: The department does not have the authority to delete the requirement because it is statutorily mandated in Insurance Code §1305.303(f). The statute specifically requires networks to develop an annual quality improvement work plan designed to reflect the type of services and the populations served by the network in terms of age groups, disease or injury categories, and special risk status, such as type of industry.

§10.81(b)(2)(B)(iii): A commenter requests clarification on the requirement to include evaluation of clinical studies in the quality improvement work plan, including but not limited to whether the department is requiring the quality improvement program to include information regarding those network plan providers who are engaged in clinical studies, particularly if the network has delegated quality improvements tasks or is not engaged in any clinical studies itself. The commenter suggests that the rule should require evaluation of quality of clinical care and quality of services as set forth in Insurance Code §1305.303 instead of clinical studies.

Agency Response: The department does not believe either change is necessary. The requirement to evaluate clinical studies applies to the network or its delegated entities.

If neither is performing clinical studies to evaluate the quality of medical care, then the method of evaluation of medical care by network providers may be substituted for this requirement.

§10.81(b)(2)(B)(iv): A commenter states that the language requiring a periodic update of treatment plans, return-to-work guidelines, and individual treatment protocols is too vague because the commenter believes that none of the guidelines in use are current.

Agency Response: The department does not agree with the commenter and declines to impose additional specific deadlines for such updating, but will monitor to determine whether additional rulemaking is needed. Insurance Code §1305.304 requires that each network adopt treatment guidelines, return-to-work guidelines, and individual treatment protocols and further specifies that treatment may not be denied solely on the basis that the treatment for the compensable injury in question is not specifically addressed by the treatment guidelines used by the carrier or network. Additionally, Insurance Code §§1305.351 – 1305.355 set forth requirements concerning utilization review, retrospective review, reconsideration, and review by an independent organization, and Insurance Code §§1305.401 – 1305.405 set forth requirements regarding complaint initiation, procedures which are available to providers or injured workers who feel that treatment guidelines are outdated. Insurance Code §1305.303(g) requires that the annual quality improvement program report must be done annually, and §10.81(b)(2)(B)(iv) clarifies that the quality improvement work plan must include an evaluation of the adoption and periodic updating of guidelines.

§10.81(b)(2)(B)(vii): A commenter requests that §10.81(b)(2)(B)(vii) be changed to require the annual quality improvement work plan to include both provider billing and provider payment processes.

Agency Response: The department agrees and has changed the language of §10.81(b)(2)(B)(vii) to “provider billing and provider payment processes, if applicable”.

§10.81(b)(2)(B)(xii): One commenter raises a concern that requiring the network to provide providers with information such as the insurer’s or the employer’s return-to-work processes and outcome data reflecting the number of time loss days paid from one year to another, for example, will present a problem for the network, which has no access to that information. According to the commenter, this concern is derived from the commenter's questions about whether the requirement that the quality improvement work plan include an evaluation of return-to-work processes and outcomes means that the network must provide educational materials to providers on the importance of focusing on return-to-work efforts, and if so, whether the expected outcome is that a certain percentage of the providers received the training.

Agency Response: Insurance Code §1305.303 requires the network’s quality improvement program to include a return-to-work program. The network quality improvement program must include monitoring of the return-to-work program and the success or failure of the program in returning injured workers to work. This process neither requires nor precludes provision of educational materials to providers. The

outcome addressed in this rule is whether employees are returning to work and not whether materials were provided to a provider.

§10.81(c): A commenter states that the department's recognition of URAC Accreditation in §10.81(c) of the proposed rules will help to achieve the legislature's goal of providing high quality care to injured workers through workers' compensation health care networks and will further the legislature's intent that the workers' compensation health care network system resemble group health insurance plans as closely as possible.

Agency Response: The department thanks the commenter for support of the proposed rules.

§10.81(c)(1): A commenter states that §10.81(c)(1) creates a presumption of compliance for certain nonconditional accreditations, but according to the commenter, these accreditations are not specific to workers' compensation requirements and do not address the particular concerns of workers' compensation certified networks. The commenter therefore requests that this special presumption should be deleted.

Agency Response: The department does not agree that the presumption should be deleted. The intent of the legislation is to model workers' compensation health care networks on group health models. Network providers will be providing health care services to injured employees, and many national accreditation entities currently review group health care organizations' quality improvement programs to ensure that the

programs meet health care standards. Since workers' compensation health care networks are providing health services, the same quality improvement standards are applicable to the networks.

§10.81(c)(1): A commenter states that language which creates a presumption of compliance for any national accreditation entity recognized by rules adopted by the commissioner of insurance should be deleted. The commenter states that this same standard should be applied in §10.102(a).

Agency Response: In response to the commenter's concerns, the department has changed proposed §10.81(c)(1) to delete the reference to "any other national accreditation entity recognized by rules adopted by the commissioner of insurance." The department does not understand the comment regarding §10.102(a), but §10.102(a) is based on the statutory requirements in Insurance Code §1305.351.

§10.81(c)(1): A commenter notes that Pain Program accreditation is not included among the accreditation entities recognized in §10.81(c)(1), and opines that this is one of the largest areas for abuse and overutilization of services.

Agency Response: The department does not believe that any change to the rule is required. The department recognizes that individual providers may be certified or accredited; however, this subsection addresses accreditation of the network itself.

§10.82: A commenter states that to avoid unnecessary administrative process, the Division should adopt a standard baseline credentialing mechanism. The commenter states that if networks wish to require additional evidence of suitability on the part of their selected providers, networks should be able to establish those criteria, but the commenter believes that the fundamental criteria set forth in a standard form and format would benefit all. Another commenter recommends that the department should specify one of the standard credentialing mechanisms for baseline credentialing, such as the Texas Standard Credentialing Application or Medicare Provider Certification. According to the commenter, if a network wishes to require additional specialty credentialing as part of its marketing program, the network should have that ability, but variations in credentialing which come about merely because networks have no guidance to utilize particular credentialing mechanisms will deter providers from participating in the system. Other commenters urge changing the rules to require the use of a standardized credentialing application.

Agency Response: The department declines to change the rule because the approach in the rule and the statute affords networks greater flexibility to review and select an appropriate credentialing mechanism. Section 10.82 establishes a standard baseline credentialing mechanism in accord with Insurance Code Chapter 1305. Section 1305.004(6) defines credentialing as a 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. Section 1305.154(b) requires a network to perform

functions related to credentialing in accordance with the requirements of Insurance Code Chapter 1305. The department will monitor the issue for possible future rulemaking.

§10.82: Commenters opine that site visits to treating providers as a required part of the credentialing process are overly burdensome and costly and ask that site visits to be optional or eliminated entirely. Another commenter requests that the rules be modified to allow networks to phase in site visits over a period of time. The commenter states that imposition of the requirement prior to the effective date of the initial contract with the provider as a requirement of network certification would be unduly burdensome to the network and providers. Another commenter recommends that the department allow established networks conditional certification until full compliance with the site visit requirement can be accomplished.

Agency Response: The department agrees with a phase-in of site visit requirements and has added §10.82(a)(1)(C)(vi) to the proposed rule to allow for a phase-in until not later than the first anniversary after the date of the network's certification. If the department or the network receives a complaint about a treating doctor who has not had a site visit, the network must perform a site visit within 30 days after notification by the department of the complaint, unless circumstances warrant an immediate site visit, and shall take action to correct any deficiencies found.

§10.82: A commenter states that if physicians are given the right to review the credentialing files, comments or notes from the physician reviewer should be excluded.

Agency Response: The department disagrees and declines to change the rule. Without the right to review comments or notes by the physician reviewer, a provider will be unable to respond to the content thereof or to correct erroneous information, which would be inconsistent with the requirement that a quality improvement program provide for a peer review action procedure as set forth in Insurance Code §1305.303(i).

§10.82: A commenter states that instead of auditing all entities to whom a network delegates, the network should be required to audit a specific percentage.

Agency Response: The department declines to make the requested change. The credentialing processes required in this section are based on national credentialing standards as required by the statute. The national credentialing standards to be reviewed require annual monitoring of all delegatees.

§10.82: Commenters state that the networks will be responsible for creating specific policies and procedures for their credentialing process but that there is no access to the specific credentialing policies by providers under the healthcare practitioner rights. Commenters request that this right be included in the rule to allow for a transparent credentialing process.

Agency Response: The department agrees that credentialing policies and procedures must be accessible to providers who are subject to the requirements and has added

clarifying language in proposed §10.82(a)(1)(B) to provide that the credentialing criteria and procedures must be made available to network providers or applicants upon request.

§10.82(a)(1)(B): Commenters opine that the requirement that networks verify the status of financial disclosure filings for each provider in the network is overly burdensome and will result in greater costs to the system. The commenters request that the language be stricken and language requiring the individual provider to certify that he or she has complied with the financial disclosure requirements of the statute be substituted.

Agency Response: The department has modified the proposed §10.82(a)(1)(B) requirement regarding financial disclosures because of technical modifications that are necessary to make information regarding financial disclosures by providers who are on the ADL available online for networks.

§10.82(a)(1)(B)(iv): A commenter states that site visits by networks are not provided for within the text of the statute. The commenter asserts that the department cannot legally grant or share its authority with a public entity such as a network. However, if the authority to require such visits exists, according to the commenter, the department should state specifically what actions are and are not permissible during such a visit.

Agency Response: The department disagrees. Insurance Code §1305.303(a) requires a network to develop and maintain an ongoing quality improvement program designed to objectively and systematically monitor and evaluate the quality and

appropriateness of care and services and to pursue opportunities for improvement. Insurance Code §1305.303(h) requires each network to implement a documented process for the selection and retention of contracted providers in accordance with rules adopted by the commissioner. The department believes that site visits are necessary to the network's quality improvement program and declines to make the requested change.

§10.82(a)(1)(B)(iv): Commenters requested changes to credentialing requirements related to time of contracting, length of credentialing process, addition of boards, limiting rights of doctors to see information, credentialing of hospital-based practitioners, monitoring of Medicare and Medicaid sanctions, selection criteria, primary source verifications, length of time to correct site visit deficiencies, and addition of the Executive Council of Physical Therapy and Occupational Therapy Examiners to the credentialing requirements.

Agency Response: The department declines to make the requested changes, as the standards are aligned with nationally recognized credentialing standards, as required by the statute. Under §1305.004(a)(6), "credentialing" means 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."

§10.82(a)(1)(B)(viii): One commenter opines that the regulation is vague, unenforceable, and susceptible to an interpretation that could undermine the reforms that the statute attempts to achieve. The commenter states that there is no recognized medical specialty in "the treatment of costly conditions." According to the commenter, it is impossible to determine if a provider is a specialist in "the treatment of costly conditions" or an outlier health care provider who over-utilizes medical treatment that turns ordinary injuries into "costly conditions."

Agency Response: The department agrees and has modified proposed §10.82(a)(1)(B)(viii) to delete the reference to those who "specialize in the treatment of costly conditions."

§10.82(a)(1)(B)(viii)(I): A commenter asks the department to establish time frames and appeal procedures and define quality of care in this section because, as proposed, the rules allow for terminations and disciplinary actions based on unproved data and out-dated research or as retribution.

Agency Response: The department declines to change the rule. Under §1305.303, the network is responsible for assuring quality of care, and the network's governing body is ultimately responsible for the quality improvement program. Insurance Code §1305.152(c) requires that provider contracts include a clause regarding appeal by the provider of termination of provider status, in addition to provisions required by the commissioner by rule. To fulfill the network's quality assurance responsibilities, it

follows that a network may suspend or terminate a doctor or health care practitioner if the network is concerned about the doctor or health care practitioner's quality of care.

§10.82(a)(1)(C)(ii), (D)(ii)(I): A commenter asks whether the rules in §10.82 indicate that if the network is accredited by the Joint Commission on Accreditation of Health care Organizations (JCAHO) and JCAHO has approved the networks credentialing policies whereby Primary Source Verification (PSV) is delegated to a JCAHO accredited hospital, the department will accept the network's PSV processes to meet this requirement.

Agency Response: Yes, those JCAHO standards that are the same, substantially similar or more stringent than rule requirements meet this requirement.

§10.82(a)(1)(C)(iv): A commenter states that JCAHO allows a network to accept completed site survey questionnaires in lieu of an on-site visit and asks whether the department will accept these processes to meet the site visit requirement.

Agency Response: No. Under §§10.81(c)(3) and 10.81(c)(4), JCAHO accreditation combined with site visits are acceptable. If a network is accredited by a national accreditation organization that has the same or similar standards as the standards required under the statute, the network is presumed to be in compliance with credentialing requirements. Because a site survey questionnaire would not comply with the site visit requirement set forth in §10.82(a)(1)(C)(iv), the site visit requirement would have to be met separately.

§10.82(a)(1)(E): A commenter requests clarification regarding whether the term "institutional provider" is different from "health care facility" as defined in the Labor Code.

Agency Response: The department clarifies that the terms have the same meaning, and has changed §10.82(a)(1)(E) to delete the term "institutional providers" and to substitute the term "health care facility" to prevent confusion.

§10.82(a)(1)(E): A commenter requests clarification regarding whether the network is able to determine that Medicare certification is required for credentialing of health care facilities.

Agency Response: The network has the ability to determine which national accrediting bodies are appropriate for different types of health care facilities. An example of a national accrediting body is the Joint Commission on Accreditation of Health Care Organizations. However, Medicare certification is a required element of the credentialing process.

§10.82(a)(1)(E)(iii): A commenter states that this provision should be changed to state that the credentialing process for institutional providers must include evidence of compliance with other state or federal requirements rather than evidence of other applicable state or federal requirements. The commenter opines that the statute does not include language that gives the department the authority to regulate the networks'

selection process for network providers. According to the commenter, this regulation conflicts with a network's ability to reject a provider's application if the network determines that the network has contracted with a sufficient number of providers. The commenter does not explain the basis for the belief that there is a conflict between the rule and the network's ability to reject an application.

Agency Response: The department agrees in part and has changed proposed §10.82(a)(1)(E)(iii) to add "compliance with" before "other applicable state of federal requirements." Insurance Code §1305.303 (h) requires the network to implement a documented process for the selection and retention of contracted providers, in accordance with rules adopted by the commissioner. Insurance Code §1305.004 defines credentialing as a review of qualifications and other relevant information relating to a health care provider under nationally recognized standards. Therefore, the credentialing standards in this rule are based on nationally recognized standards, including NCQA, URAC, and JCAHO. The department does not agree that the rule conflicts with a network's ability to reject a provider's application with the network determines that the network has contracted with a sufficient number of providers because §10.42(a) expressly states that the network does not have to accept the application of a provider if it has determined it has sufficient providers of the same type already in the network.

§10.82(b): A commenter believes that the term "for cause" is vague and requests that the department define the term. The commenter believes that in the absence of a

specific definition, lawsuits will put health care providers, networks and the department at the mercy of the courts.

Agency Response: The department declines to change the rule because it is the department interpretation that the statute is clear that quality issues are the responsibility of and within the discretion of the networks. Insurance Code §1305.303 requires the network to develop and maintain an ongoing quality improvement program, and the network's governing body is ultimately responsible for the quality improvement program.

§10.82(c): A commenter requests that the rule mandate that the required peer review process be performed by a doctor of the same specialty as the doctor being reviewed and cites an example of a pharmacist performing a medical necessity peer review on a physical medicine and rehabilitation specialist.

Agency Response: The department declines to make the requested change because the peer review process described in this subsection is not the same as the peer reviews performed to determine medical necessity in the utilization review process. The peer review process required under the Medical Practice Act examines quality of care and provider misconduct, rather than medical necessity.

§10.82(d): A commenter requests clarification that the rule requires the network to audit a percentage of a network's delegated entities and states that a requirement to audit all delegated entities would be overly expensive and burdensome.

Agency Response: The department disagrees and declines to make the requested change. Under the rule, networks are required to perform ongoing monitoring of all of the delegated entities with which they contract. The audits may be performed on a sample of files rather than reviewing all files, according to the network's monitoring plan.

§10.82(d)(2): A commenter questions whether the same rule for NCQA delegated entities applies if the network is accredited by JCAHO.

Agency Response: The same rule applies. The department has modified the proposed rule to specify that several national accreditation organizations other than the NCQA are acceptable.

§10.82(d)(4): One commenter opines that the language should be changed to permit the department to "inspect" the credentialing files of a delegated entity, while another commenter states that substituting the term "inspection" means that the department would have to visit the network instead of the network sending credentialing files to the department.

Agency Response: The department disagrees with both comments. Insurance Code §1305.251 grants the department the authority to examine the network's operations whether the review be on-site or at the department.

§10.83, §10.83(a), and §10.2: A commenter opines that networks are not qualified to develop treatment guidelines and individual treatment protocols and that individual

treatment protocols can be developed only by the evaluating therapist and doctor. According to the commenter, treatment guidelines have been used to deny treatment to or reduce reimbursement for severely injured patients, and that non-medical network employees are situated to decide what treatment is appropriate. Another commenter raises a concern that treatment guidelines are outdated and fail to consider the severity of an injury, the healing process of the individual patient, or the patient's job requirements. Another commenter requests that the language of §10.83(b) be changed to ensure that carriers and networks may not deny coverage for a compensable injury based upon a treatment guideline unless the guideline specifically addresses the injury and the treatment for the specific indication being requested. The commenter further requests that language be added to prohibit a carrier or network from denial of coverage based upon a treatment guideline that does not specifically address the injury and the treatment for a specific indication in question. Other commenters state that specific treatment guidelines are unnecessary but should be consistent between networks if developed because it will otherwise be burdensome for providers to acquire and learn each different treatment guideline. Another commenter states that to achieve quality care and cost efficiency, all groups should work from the same scientific evidence base to ensure consistency within the workers' compensation system. According to the commenter, the studies by the National Institute of Medicine and the history of the use of adopted guidelines in California are instructive, demonstrate cost-saving potential, and support the use of evidence-based medicine as the basis for adopted treatment guidelines. Still another commenter opines that the presence of multiple guidelines

within and between networks will create the potential for workers to receive differing levels of care; create uncertainty among stakeholders as to what is best for individual workers; and lead to increased delays and costs due to disputes. This commenter recommends that the department adopt the ACOEM Occupational Medical Practice Guidelines for use by workers' compensation networks.

Agency Response: The department does not have the authority to delete the requirement that each network adopt treatment guidelines and individual treatment protocols because the requirement is mandated in Insurance Code §1305.304. In addition, individual networks have discrete responsibilities to adopt treatment guidelines, and Insurance Code Chapter 1035 does not direct the department to prescribe particular treatment guidelines. Insurance Code §1305.304 specifies that a carrier or network may not deny treatment for a compensable injury solely because its treatment guidelines do not specifically address the treatment or injury. Coverage for treatment will largely be determined by medical necessity. Labor Code §408.021(a) states that an employee who sustains a compensable injury is entitled to all "health care" reasonably required by the nature of the injury as and when needed. Insurance Code §1305.004(b) incorporates the definition of "health care" in Labor Code §401.011(19), which includes all reasonable and necessary medical aid, medical examinations, medical treatments, medical diagnoses, medical evaluations, and medical services. As a further protection, §10.101(b) of these rules specifies that the carrier's utilization review program and retrospective review program must include a process for a treating doctor or specialist to request approval from the network for

deviation from the treatment guidelines, return-to-work guidelines, and individual treatment protocols where required by the particular circumstances of an employee's injury. Furthermore, the rules contemplate that deviations may be requested by a specialist, and injured workers have access to specialists. Finally, the provider and injured employee have access to the independent review organization process and the complaints process if a dispute arises regarding deviations from treatment guidelines.

§10.83: A commenter opines that physical therapy services should be exempt from treatment guidelines, citing its belief that no published treatment guideline is considered evidence-based, scientifically valid, and outcome-focused for physical therapy for an injured worker. According to the commenter, guidelines adopted in other states have proven insufficient and have caused chaos in the system by: requiring injured workers to return to work with insufficient care to avoid re-injury; creating burdensome processes for providers, networks and payors to revise treatment plans to effectively manage a patient; causing physical therapy providers to opt not to participate in the workers' compensation system; and resulting in the use of treatment guidelines as limitations on care. The commenter also recommends requiring pre-authorization of all physical therapy care, with existing guidelines made available to providers and carriers as a guide rather than a limit on treatment.

Agency Response: The department does not have the authority to delete the requirement that each network adopt treatment guidelines and individual treatment protocols because the requirement is mandated in Insurance Code §1305.304.

Providers and networks are well-positioned to address issues of treatment guidelines and individual protocols during the contracting process. While Labor Code §413.014 includes required preauthorizations for physical therapy services, that statute does not apply to workers' compensation networks pursuant to Insurance Code §1305.351(c). Further, while Insurance Code §1305.351(c) does not require networks to preauthorize services, if a carrier or network does use a preauthorization process, the requirements of Insurance Code §§1305.351-1305.355 and Chapter 10 of these rules apply. Networks and carriers shall decide which services, if any, will be subject to preauthorization, as set forth in §10.102 of these rules.

§10.83(a): One commenter suggests that, given the requirement that each network adopt evidence-based, scientifically valid, and outcome-focused guidelines, the department should add a new subsection requiring that a carrier or network provide health care in accordance with best practices consistent with "generally accepted standards of medical practice recognized in the medical community" to address situations in which no evidence exists or conflicting evidence exists with regard to treatment guidelines or if treatment guidelines or protocols do not address a specific injury or treatment requested or provided. The commenter states that this addition would be consistent with definitions of evidence-based medicine in the statute and in the Labor Code. Another commenter opines that the rule should require that authorized treatment that is not addressed in the treatment guidelines be in accordance with other evidence-based and scientifically valid medical treatment guidelines that are generally

recognized by the national medical community because such language would allow for deviations from adopted treatment guidelines where necessary while ensuring that the deviation remains consistent with principles of evidence-based medicine. According to the commenter, the provider requesting a deviation from treatment guidelines should be required by the rules to provide a compelling reason for such deviation.

Agency Response: The department declines to make the requested changes because the department does not believe that they are necessary. Section 10.101(b) of these rules specifies that the carrier's utilization review program and retrospective review program must include a process for a treating doctor or specialist to request approval from the network for deviation from the treatment guidelines, return-to-work guidelines, and individual treatment protocols where required by the particular circumstances of an employee's injury. The department contemplates that deviations from treatment guidelines will be governed by medical necessity and that networks will develop processes to review requests for deviation, whether during utilization review or retrospective review. Providers and networks are well-positioned to address issues of treatment guidelines and individual protocols during the contracting process. The department will closely monitor the treatment of requests for deviation to determine whether future rulemaking is required.

§10.83(a): Commenters state that appropriate treatment guidelines include national specialty guidelines that are transparent, peer reviewed, and evidence-based. One commenter opines that guidelines published by the National Guidelines Clearinghouse

meets these requirements and requests that these quality indicators be included as part of the rule.

Agency Response: The department declines to make the requested change because §10.83(a) requires that networks adopt treatment guidelines that are evidence-based, scientifically valid, outcome-focused, and designed to reduce inappropriate or unnecessary health care while safeguarding access to necessary care. In addition, networks, as they undertake the treatment guidelines adoption process, are not precluded from consideration of the quality indicators noted by the commenter.

§10.83(a): A commenter asks that the department impanel a group representative of all health care provider groups to write the guidelines so that they will be known to providers, accessible to any interested party, and enforceable. According to the commenter, current treatment and return-to-work guidelines are considered proprietary by networks and carriers and are only revealed to providers as a part of their termination from the network.

Agency Response: The department does not have the authority to make the requested changes because each individual network has the discrete responsibility to adopt treatment guidelines pursuant to Insurance Code §1305.304, and the statute does not direct the department to prescribe particular treatment guidelines. Insurance Code §1305.152(c)(2) requires provider contracts and subcontracts with a network to include a statement that the provider agrees to follow treatment guidelines adopted by the network, as applicable to an employee’s injury. Section 10.83(c) of these rules

requires networks to assure that all treatment guidelines, return-to-work guidelines, and individual treatment protocols are made accessible to all providers.

§10.83(a): A commenter opines that treatment guidelines should be recognized and accepted by the specific health care provider group as valid guidelines for the care provided; e.g., occupational therapists would accept guidelines for occupational therapy care. The commenter recommends the development of a process for deviation from the treatment guidelines as indicated.

Agency Response: The department declines to make the requested changes because each individual network has the discrete responsibility to adopt treatment guidelines pursuant to Insurance Code §1305.304, and the networks will establish their own process for adoption of such guidelines. In addition, the networks are not precluded from utilizing specialty provider groups in this consideration and adoption process. Section 10.101(b) specifies that the carrier must establish a process for review of requests to deviate from treatment guidelines, whether as a part of utilization review or as a part of retrospective review. The process must include a requirement that the doctor or specialist request approval from the network for deviation from the treatment guidelines, return-to-work guidelines and individual treatment protocols where required by the particular circumstances of an employee’s injury. Furthermore, these rules contemplate that deviations may be requested by a specialist, as injured workers have access to specialists. Finally, the provider or injured employee has access to the independent review organization process and the complaints process if a dispute arises

regarding deviations from treatment guidelines. Consistent with the statutory requirements set forth in Insurance Code §1305.354(b), §10.103(b)(2) additionally requires that reconsideration procedures include a review by a provider who has not previously reviewed the case who is of the same or a similar specialty as a provider who typically manages the condition, procedure, or treatment under review.

§10.83(b): A commenter supports the provision that a carrier or network may not deny treatment for a compensable injury solely because its treatment guidelines do not specifically address the treatment or injury and asserts that it should be strictly enforced.

Agency Response: The department appreciates the commenter's support. The department will closely monitor the utilization of treatment guidelines and will take enforcement action as necessary.

§10.83(c): A commenter requests that the rules require that a network's quality improvement program, guidelines and protocols be made available to providers before the provider contract is signed so that providers have a clear understanding of the policies and practices the network will require of them. Other commenters note that §10.83(c) could be interpreted to require a network to purchase costly copies of the treatment and return-to-work guidelines it uses for each of the providers contracted with the network and request a clarification stating that the network is responsible for informing the provider of the source of the treatment and return-to-work guidelines used

by the network and that the provider is responsible for obtaining copies of those guidelines. Alternatively, commenters suggest that the rule require the network to "communicate" rather than "make available" the treatment and return-to-work guidelines.

Agency Response: Networks and providers are well-positioned to share requisites of the network's quality improvement program, guidelines and protocols during the contracting process. The department anticipates that individual providers will require access to the quality improvement program, guidelines, and protocols prior to signing a contract. The department has modified proposed §10.83(c) to clarify that a network must assure that all treatment guidelines, return-to-work guidelines, and individual treatment protocols are made accessible to all network providers. The network may provide this information using any reasonable method that is accessible by the physician or provider, including e-mail, computer disks, paper or access to an electronic database.

§10.83(c): A commenter raises concern with the requirement in §10.83(c) that the network contractually require providers to follow treatment guidelines, return-to-work guidelines, and individual treatment protocols and requests that resultant disputes be addressed with peers of the same specialty as the provider who requests approval to deviate from guidelines rather than with an adjuster or case manager. The commenter requests clarification of who determines individual treatment protocols, and expressed

fear that if a case manager has this responsibility, the case manager will be practicing medicine without a license.

Agency Response: The department does not have the authority to delete the requirement mandated in Insurance Code §1305.152(c)(2) that provider contracts and subcontracts include a statement that the provider agrees to follow treatment guidelines adopted by the network under §1305.304, as applicable to the employee's injury. Individual networks have discrete responsibilities to adopt treatment guidelines under Insurance Code §1305.304, and the department anticipates that the individuals or groups who undertake the adoption process at each network will vary between networks. The department declines to make the requested change on resultant disputes because it is the department's position that since a request to deviate from the treatment guidelines is required to be a part of the utilization review or retrospective review programs, §10.103(b)(2), which requires that the reconsideration process include a review by a provider who is of the same or a similar specialty as a provider who typically manages the condition, procedure or treatment under review, is sufficient.

§10.84: A commenter asserts that treating doctors must also be allowed to serve as designated doctors or there will be no doctors to provide primary care for the injured workers.

Agency Response: Insurance Code §1305.101(b) states that a network doctor may not serve as a designated doctor or perform a required medical examination, as those terms are used under the Texas Workers' Compensation Act, for an employee receiving

medical care through a network with which a doctor contracts or is employed. Insurance Code Chapter 1305 does not prevent a network treating doctor from serving as a designated doctor for a patient in another network with whom the doctor is not contracted or employed.

§10.84: A commenter supports the provision in §10.84 that reflects the authority of networks to designate treating doctors and treating doctor specialties.

Agency Response: The department appreciates the commenter's support.

§10.84: A commenter states that the authority to define the term "treating doctor" is specifically given to the department by the legislature in the statute and that the department, rather than the insurance industry or networks, should specify by rule the definition of the term and show the criteria used to draft the definition.

Agency Response: The department declines to make this change because Labor Code §401.011(42) defines "treating doctor" and this definition is incorporated by reference in Insurance Code §1305.004(b)(10) and §10.2(b)(13). Insurance Code §1305.103(a) states that the network shall determine the specialty or specialties of doctors who may serve as treating doctors.

§10.85: A commenter expressed concern that the rules do not support a proposed referral system in the best interest of the patient or in support of cost-savings. The commenter states that surgical physicians are currently required to refer patients back

to referring physicians once surgery is performed without consideration of the referring physician's ability to acquire or monitor therapy. According to the commenter, if a patient receives necessary care by a qualified licensed therapist, or a doctor with necessary training, appropriate care can be given initially, complications reduced, and the patient returned to work more quickly. The commenter suggests that the rule specify that if a patient requires emergency surgery, the doctor responsible for surgery should be the treating doctor and refer the patient for needed services. The commenter also suggests that the rule state that if a treating doctor refers a patient for surgery, the surgeon shall be the treating doctor and refer the patient for needed services related to the surgery. The commenter further suggests that when the surgery and related services are completed, the patient should then return to the original doctor.

Agency Response: The department does not have the authority to make the requested changes because Insurance Code §1305.103(a) requires that networks determine the specialty or specialties of doctors who may serve as treating doctors. Insurance Code §1305.103(e) requires that a treating doctor make referrals to specialists as needed. A referral to a surgeon should additionally allow the referral provider to provide reasonable related subsequent care as necessary.

§10.85: A commenter recommends that all employees be given a provider book for workers' compensation injuries similar to that of preferred provider organizations because the preferred provider organization system has worked well and is one with which most employees are familiar. According to the commenter, if employees obtain

the list from the human resources department at the time of injury, the employees may be pressured or manipulated into going to doctors who have been promised economic benefit incentives for considering cost of the patients' care.

Agency Response: The department does not have the authority to make the requested change because it conflicts with the statutory provisions. Insurance Code §1305.005 requires that the employees be given a notice of network requirements and the employee information described in Insurance Code §1305.451, which includes a list of network providers updated at least quarterly. By statute, this notice must be given to current employees when the employer implements a network plan, to new employees within three days of hire, and to injured employees when the employer receives constructive notice of the injury. Under §10.60(g)(14), the employee must receive the complete list of network doctors at all required times for receiving the notice. If the department receives complaints from employees that they were manipulated into choosing from less than the entire list, the situation would be investigated and enforcement action taken as necessary.

§10.85: Commenters opine that §10.85 is confusing and request a change to the section to require: that an injured employee required to receive health care services with a network may select as the employee's treating doctor a doctor who the employee selected, prior to the injury, as the employee's primary care physician or provider under Chapter 843, as the terms "physician" and "provider" are defined in that chapter; that the doctor must agree to abide by the terms of the network's contract and to comply with

the provisions of Subchapters B, D, and G of Chapter 1305 of the Insurance Code; that services provided by the doctor are considered to be network services and are subject to Subchapters H and I of Chapter 1305 of the Insurance Code; and that any change of doctor requested by an employee being treated by a doctor under this subchapter must be to a network doctor.

Agency Response: The department disagrees with the commenters' apparent belief that Insurance Code §1305.105 and §10.85 require that the HMO primary care physician be selected as the workers' compensation network treating physician prior to the injury. Such an interpretation would conflict with Insurance Code §1305.103(b), which states in part that an injured employee shall select a treating doctor for each injury. To prevent continued confusion, the department has modified proposed §10.85(d) to more closely track the language of Insurance Code §1305.105(a). The department has also added language to proposed §10.85(d) to recognize that not all provisions contained in Subchapters D through I of Chapter 1305 and commissioner rules adopted under those subchapters apply to treating doctors. The department declines to make any change that conflicts with Insurance Code §1305.104(a) and (b) because the department does not wish to impede the network's ability to allow for selection of a treating doctor from outside the network if the network so chooses. While Insurance Code §§1305.104(a) and (b) make clear that initial selection of a treating doctor and selection of an alternate doctor must be from within the network, selection of a subsequent treating doctor must be authorized only according to procedures and criteria established by the network as set forth in Insurance Code §1305.104(c).

§10.85(a): A commenter requests a revision of §10.85(a) to reflect that the selection of the treating doctor must be from the list provided by the network of all contracted treating doctors designated by the network.

Agency Response: The department declines to make this change because to do so would deprive an injured employee who is covered under an HMO plan of the right to select the employee's HMO primary care physician or provider as the treating doctor in accordance with Insurance Code §1305.105. The language in §10.85(a) mirrors Insurance Code §1305.104(a) which entitles the employee to his or her initial choice of a treating doctor from the networks' list of treating doctors.

§10.85(d): Commenters note the importance of insurer and network knowledge of the identity of the injured employee's treating doctor for purposes of claim investigation, determination of what the compensable injury is, initiation of contacts with the treating doctor, initiation of case management, coordination of healthcare requests by referred healthcare providers with the treating doctor, and follow-up on quality of health care issues. The commenters therefore request that the department add a new subsection to require that an injured employee notify the insurance carrier and network of the employee's choice of treating doctor and any subsequent change of treating doctor in accordance with §1305.104(b) – (e) of the Texas Insurance Code. The commenters also request language stating that the network shall notify the insurance carrier of any decision made by the network's medical director to allow the injured employee to use a

specialist as the employee's treating doctor in accordance with §1305.104 (f) – (i) of the Texas Insurance Code.

Agency Response: The department declines to make these requested changes because such provisions could affect or delay the employee's right to timely receipt of services. Pursuant to Insurance Code §1305.104(b), an employee who is dissatisfied with the initial choice of treating doctor is entitled to select an alternate treating doctor from the network's list of treating doctors who provide services within the service area in which the injured employee lives by notifying the network in the manner prescribed by the network. The carrier and network are well-positioned to negotiate additional notifications between the carrier and network during the contract process, but such provisions should not affect or delay the employee's right to timely receipt of services.

§10.85(d): A commenter raises concern that the language in this subsection does not actively reflect the statute in that the proposed rules appear to state that the employee must select the workers compensation provider prior to the employee's injury, whereas the commenter believes the statute only requires that the person have selected their HMO primary care provider prior to their injury.

Agency Response: The department agrees with the commenter's concern and has modified proposed §10.85(d) to more closely track the language of Insurance Code §1305.105**.**

§10.85(b): A commenter recommends that the title of §10.85(b) be revised to clarify that the provision addresses a change of treating doctor within the network.

Agency Response: The department does not agree with this change because it could impede the network's ability to allow for selection of a treating doctor from outside the network if the network so chooses. Insurance Code §1305.104(b) makes clear that an alternate doctor must be a network doctor. However, selection of a subsequent treating doctor must be authorized only according to procedures and criteria established by the network as set forth in Insurance Code §1305.104(c).

§10.85(c): A commenter recommends that it will better reflect statutory intent to change §10.85(c) to provide that the injured employee may apply to the network's medical director to use a specialist that is in the same network as the injured employee's treating doctor for either all health care or for all health care related to the treatment of chronic pain. Another commenter raises concern that §10.85(c) may suggest that specialists cannot be considered treating physicians from inception of the injury and expresses fear that employees will always need to undertake a complicated process to obtain a specialist as their treating doctor.

Agency Response: The department does not have the authority to change the requirement in Insurance Code §1305.104(h) that a physician specialist, if serving as a treating doctor, must agree to accept the responsibility to coordinate all of the injured employee's health care needs. Insurance Code §1305.104 provides that any doctor listed as a treating doctor in the list provided quarterly by the network, regardless of

specialty, may be initially selected by the employee as an initial or alternate treating doctor.

§10.85(d): Commenters support this provision in that it tracks statutory language and requires selection of the treating physician prior to the injury. Commenters request an addition to §10.85(d) to require an employee to provide both proof that selection of the primary care physician used by the employee in the employee's HMO as the employee's treating doctor occurred prior to the date of injury and proof that the primary care physician has agreed to abide by the terms of the network's contract and comply with the applicable provisions of the statute. According to the commenter, the employee is best-positioned to provide this information. Similarly, some commenters urge that the rules be changed to require that an employee is responsible for contacting the HMO primary care physician regarding selection as a treating doctor and obtaining the doctor's agreement, on a form designated by the network, prior to the injury, because care will otherwise be delayed. Another commenter notes that employers hold employees' private medical plan information and are thus positioned to confirm an employee's status as a participant in an HMO. The commenter therefore requests that a form be developed for submission by the employee to the employer containing the employee's selection of the HMO primary care physician as the treating doctor in the workers' compensation network prior to the injury, which form would include the employee's signature, the name of the medical provider, and a signed statement from the provider agreeing to abide by applicable statutes and regulations.

Agency Response: The department disagrees with the commenters' apparent belief that Insurance Code §1305.105 and §10.85 require that the HMO primary care physician be selected as the workers' compensation network treating doctor prior to the injury. Such an interpretation would conflict with Insurance Code §1305.103(b), which states in part that an injured employee shall select a treating doctor for each injury. To prevent continued confusion, the department has modified proposed §10.85(d) to more closely track the language of Insurance Code §1305.105(a). The department disagrees that the injured employee is best-positioned to act as middleman between the carrier and physician, as the employee has no knowledge of a network's contract terms or the applicable provisions of the statute. A carrier has several options for obtaining proof that the employee selected the HMO physician prior to the date of injury, including, but not limited to, obtaining a copy of HMO ID cards. The department declines to dictate which option a carrier should choose. The department does not believe that a form needs to be developed or that the request should be required to be submitted through the employer. The department declines to develop or require use of such a form, as it could create further delays to care of the injured employee.

§10.85(d): A commenter requests a technical change to §10.85(d) wherein the final sentence would read: "The network shall grant an employee's request…" rather than "a" employee's request…"

Agency Response: The department agrees and has made a change to grammar and punctuation in this subsection.

§10.85(d): Commenters request that the rules specify that a primary care physician is not available for choice as an alternate treating doctor because the statute is clear that any change of treating doctor must be within the network.

Agency Response: The department agrees with the commenter that the statute is clear and therefore the requested change is not necessary.

§10.86: A commenter states that this entire section should change to require each network to establish and maintain claims receipt logs that accurately record the date the network received the claim; the date the claim was approved for payment; the date the check was issued for payment; and the date check was mailed for payment.

Agency Response: The department declines to make the requested change because this section implements Insurance Code §1305.107, which addresses telephone access for discussion of employee care and for responses to requests for information, including information regarding adverse determinations. The commenter's request is directed to provider payment concerns which are addressed in Labor Code §408.027.

§10.86: A commenter requests clarification of the intent of §10.86, stating that if the section's purpose is to ensure adequate network access and availability, this can be accomplished by requiring networks to maintain around the clock access through the toll-free number already required under §10.60(g)(2). Alternatively, the commenter states that if the section's purpose is to address complaints and grievances, the

commenter feels the need is already addressed in §§10.120 and 10.121. According to the commenters, a requirement that networks maintain a system log would be overly burdensome and difficult to manage. Some commenters opine that the provisions of §10.86 exceed statutory language, constitute micromanagement of the networks' day-to-day operations, and are thus contrary to the intent of the Texas Legislature and author of the statute. The commenters request that the department either delete §10.86 or substitute the language of Insurance Code §1305.107 for the language as proposed.

Agency Response: The department declines to make the requested changes because the information required to be provided under §10.86 is the minimum information a network must be able to demonstrate that it provides in order to show itself compliant with Insurance Code §1305.107, which provides a mechanism for discussion of employee care and response to requests for information, including information regarding adverse determinations.

§10.86: A commenter believes that all information regarding the set up and maintenance of telephone access, call documentation, and access logs should be available under the Texas Open Meetings Open Records Act in order to protect all parties from unsubstantiated accusations.

Agency Response: Networks are not generally required to file telephone access logs with the department. With regard to such information if filed with the department, the department will comply with all requirements of the Public Information Act.

§§10.100, 10.101 and 10.102: A commenter asserts that utilization reviews should only be conducted by health care providers licensed in the state of Texas. In recognition of the role of paper review in utilization review, cost control and quality of care determinations, and in the absence of printed published standards, the commenter requests that paper review opinions be held to standards as set forth in the TCA Quality Standards for Opinions Based Upon Paper Review by department rule.

Agency Response: There is no statutory or regulatory requirement that utilization review be conducted by health care providers licensed in Texas. The department does not have the authority to make the requested change because of the provision in Insurance Code §1305.304 that provides that each network will adopt treatment guidelines, return-to-work guidelines and individual treatment protocols and the provision in §1305.351(b) that provides that any screening criteria used for utilization review or retrospective review related to a workers' compensation health care network must be consistent with the network's treatment guidelines. Consistent with §1305.304, §10.83(a) provides that each network will adopt treatment guidelines, return-to-work guidelines and individual treatment protocols. Section 10.101(a) requires that "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. Section 10.101(b) requires that the carrier's utilization review program and retrospective review program must include a process for a treating doctor to request approval from the network for a deviation from adopted guidelines and protocols where required by the

particular circumstances of the injury. The department anticipates that approvals for such deviations will be governed by medical necessity. No further change to the language is required.

§§10.100-10.104: A commenter states that the utilization review guidelines should interface with case management and cost containment in terms of the return-to-work guidelines.

Agency Response: Insurance Code §1305.303(j) requires networks to have case management programs with certified case managers and requires case managers to work with treating doctors, referral providers, and employers to facilitate cost-effective care and employee return-to-work. Section 10.81(a) requires networks' quality improvement programs to include return-to-work and medical case management programs.

§10.101: A commenter states that treatment guidelines should not be used to arbitrarily deny treatment, but networks should insist on a compelling reason to deviate from the guidelines before nonconforming requests are approved. According to the commenter, traditional definitions of appropriateness for many tests and treatments are generated from the prior interpretations of workers' compensation statutes rather than based in evidence; therefore, the commenter suggests a change to the language to require that treatment not addressed in the treatment guidelines be in accordance with other

evidence-based medical treatment guidelines that are generally recognized by the national medical community and that are scientifically valid.

Agency Response: Section 10.101(b) specifies that "the carrier's utilization review program and retrospective review program must include a process for a treating doctor or specialist to request approval from the network for deviation from the treatment guidelines, return-to-work guidelines, and individual treatment protocols where required by the particular circumstances of an employee's injury." The department contemplates that deviations from treatment guidelines will be governed by medical necessity. Also, the provider and injured employee have access to the independent review organization process and the complaints process set forth in Subchapters F and G of the rules if a dispute arises regarding deviations from treatment guidelines. The rule is consistent with the statute in §1305.304. Section 1305.304 provides that treatment may not be denied solely on the basis that the treatment for the compensable injury in question is not specifically addressed in a carrier's or network's adopted treatment guidelines. Section 10.42(b)(2) indicates that a provider has an obligation to follow a network's adopted treatment guidelines, return-to-work guidelines, and individual treatment protocols as applicable.

§10.101: A commenter requests details about the process for requesting a deviation from treatment guidelines, screening criteria and individual treatment protocols because such a process will be time-consuming for the physician's staff. The commenter further

requests that a resolution of the request should occur within 72 hours from the date of request.

Agency Response: The department disagrees that the department should provide the process details as requested by the commenter because to assure flexibility and maximum quality improvement, networks should develop this process, including timelines for a response to the request. Therefore, §10.101 requires the network to develop a process for requests from providers to deviate from the treatment guidelines, return-to-work guidelines and individual treatment protocols where required by the particular circumstances of an employee's injury.

§10.101: A commenter opines that it is important for these rules to be consistent with Insurance Code Article 21.58A §4(i), and states that screening criteria must be used to determine only whether to approve the requested treatment. The commenter also opines that denials must be referred to an appropriate physician, dentist, or other health care provider to determine medical necessity.

Agency Response: The rules do not deviate from the statutory requirements relating to the use of screening criteria or the involvement of an appropriate provider upon issuance of an adverse determination. Insurance Code §1305.351 and §10.100 provide that the requirements of Insurance Code Article 21.58A apply to utilization review conducted in relation to workers' compensation health care network. However, in the event of a conflict between Insurance Code Article 21.58A and Chapter 1305, Insurance

Code Chapter 1305 controls. Accordingly, utilization review performed in relation to the network will be consistent with Article 21.58A unless a conflict with Chapter 1305 exists.

§10.101(b): Commenters disagree with the proposed language in §10.101(b) that requires that a carrier's utilization review program include a process requiring a treating doctor or specialist to request approval from the network to deviate from treatment guidelines, screening criteria, and individual treatment protocols. The commenters do not agree that the statute requires such approval but instead contemplates that high-performing providers should be allowed to so deviate, at the carrier's or network's discretion. Other commenters recommend deletion of this subsection because Insurance Code Chapter 1305 authorizes networks to determine which services are subject to preauthorization within the scope of the contract between the provider and the network. According to the commenters, the proposed subsection would mandate that services be preauthorized in situations that are not contemplated in the law. Another commenter states that treating doctors and specialists will need to document the medical necessity of providing health care that deviates from the treatment guidelines, screening criteria, and individual treatment protocols and that health care should be reviewed on a retrospective basis to determine if the deviation was appropriate and if the health care was reasonable, medically necessary, and related to the compensable injury.

Agency Response: The department recognizes that in a system in which providers must follow a network's selected treatment guidelines, return-to-work guidelines and

individual treatment protocols, it is necessary to provide a mechanism by which the provider may request a deviation from such guidelines where the individual circumstances of a case so justify. The adopted rules allow networks to set up their own processes for responding to requests for deviation; proposed §10.101(b) has been modified to require that the carrier's utilization review program and retrospective review program include a process for a treating doctor or specialist to request approval from the network for deviation from the treatment guidelines, return-to-work guidelines, and individual treatment protocols where required by the particular circumstances of an employee's injury.

§10.102: A commenter states that he already struggles because the carriers have three days to deal with pre-authorization and take every bit of three days. The commenter requests that the rules require that pre-authorization requests be addressed by the network within 24 hours..

Agency Response: The department does not have the authority to make the requested change because the three-calendar-day requirement is mandated under Insurance Code §1305.353(c) and (d). Section 10.102(a) provides that 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.

§10.102: A commenter supports preauthorization without retrospective review and would like to return to preauthorization that has some defined parameters that give providers a guideline as to what they can expect.

Agency Response: Insurance Code §1305.351(c) provides that if a network or carrier uses a preauthorization process within a network, the utilization review and retrospective review requirements of Subchapter H of Chapter 1305 and the commissioner rules apply. Networks and carriers are free to structure their preauthorization procedures as they choose consistent with Subchapter H of Chapter 1305 and the commissioner rules.

§10.102(a): A commenter states that this subsection is contradictory to the statute because preauthorization does not apply to network providers. The commenter states that if network has preauthorization requirements, then the Insurance Code applies. If so, the commenter believes that retrospective review should not apply.

Agency Response: The department disagrees that this subsection is contradictory to the statute. The commenter, however, is correct that Insurance Code §1305.351 does not require preauthorization, but if a carrier or network uses a preauthorization process within a network, the provisions of Insurance Code §§1305.351 – 1305.355 and this chapter control. The commenter is also correct that a service that has been preauthorized will not be subject to retrospective review. Insurance Code §1305.153(b) prohibits a carrier or network which has preauthorized a health care service from denying payment to a provider except for reasons other than medical necessity, and

Insurance Code §1305.004(a)(21) defines "retrospective review" as the process of reviewing the medical necessity and reasonableness of health care that has been provided to an injured employee.

§10.102(a): Commenters agree with §10.102(a) of the proposed rules, but state that because the statute and the rules create separate preauthorization requirements for networks, it is important that carriers, networks, and providers have a clear understanding of the meaning and effect of preauthorization.

Agency Response: The department disagrees that the statute and rules create separate preauthorization requirements. While the adopted rule does not contain all of the statutory provisions, the statute and rules together contain compatible preauthorization requirements. The statute and rule must be read together. The department believes that the statutory definition of "preauthorization" is clear and understandable for all parties. Insurance Code §1305.153(b) provides that services that have been preauthorized may not be later denied due to lack of medical necessity. The department believes this is a clear directive to networks and is also understandable for providers and other parties.

§§10.102(b), 10.102(c)(3) and 10.103(a)(4)(B)(v): The commenter requests that more specific information be included in the notice of adverse determination so that providers fully understand the reason for a denial of a treatment or service.

Agency Response: The department declines to make the requested change because the department believes that the provisions contained in the statute and in §10.102(c) include adequate information, such as the principal reasons and clinical basis for the determination, to enable a provider to understand the basis of the decision.

§10.102(b): The commenter believes that a designated representative of the employee, including office staff or a referral health care provider, should be able to request preauthorization or appeal a denial as allowed under the existing TWCC rules that address this issue. In addition, the commenter requests a change in language to require a person performing utilization review to notify such a designated representative of a determination.

Agency Response: The requested change is not necessary. Section 10.102(b) requires that the person performing utilization review notify the employee's representative and the requesting provider of the determination. If an employee has designated a representative, there is nothing in the statute or the rules preventing the representative or the treating provider from participating in the applicable portions of the utilization review process, including appeals and preauthorizations.

§10.102(c)(4): Some commenters opine that Labor Code §408.023(h) should govern §10.102(c)(4) rather than Labor Code §408.0231(g), which is specific to peer reviews. One commenter therefore request a language change to reflect that a notice of adverse determination must include, for any provider consulted, validation that the provider is

licensed in Texas or under the direction of a doctor licensed to practice in this state in accordance with Labor Code §408.023(h). Another commenter requests deletion of the provision.

Agency Response: The department agrees that Labor Code §408.0231(g) is specific to peer reviews and, in §10.102(c)(4), has deleted "and a validation that the provider is licensed in Texas in accordance with Labor Code §408.0231(g)". The department does not have the authority to require Texas licensure for providers involved in the utilization review decision. Utilization review by networks or their designees is governed by Insurance Code Chapter 1305 and Article 21.58A. These statutes do not require Texas licensure for providers involved in the utilization review decision.

§§10.102(d) and (g): A commenter recommends additional language requiring that, on receipt of a preauthorization request from a provider for proposed services, equipment or supplies, the insurance carrier or network shall issue and transmit a determination indicating whether the proposed health care services are preauthorized within 48 hours.

Agency Response: The department does not have the authority to make the requested change because the deadlines for a response to a request for preauthorization are mandated by the applicable statutes in Subchapter H, relating to utilization review and retrospective review.

§10.102(d): Commenters request that this provision be expanded to allow a provider to seek preauthorization of any proposed service and not just those services that must be

pre-authorized. Another commenter requests that the department add a new subsection to §10.102 stating that a carrier may not deny payment to a provider except for reasons other than medical necessity if a carrier or network preauthorizes a service or item under this subchapter.

Agency Response: The department does not have the authority to allow a provider to seek preauthorization of any proposed service because Insurance Code §1305.351 does not require a network to use preauthorization of services. It is not necessary to make the requested change relating to preauthorized services and the prohibition against denials based on medical necessity because it is in the statute and is applicable to networks whether included in the rule or not. The statute and the rule must be read together.

§§10.102(d), 10.102(f) and (g): The commenter requests language stating that no retrospective denial will be allowed, noting that networks are seeking up to 35% discounts from current workers' compensation fee guidelines and that providers may not be able to afford to continue providing service to workers' compensation patients. According to the commenter, retrospective denials have resulted in marked financial loss for providers and the new rules make it more difficult for providers to contest denials, making it essential that the insurance company be required to respond to providers' request for preauthorization with no right to deny retrospectively.

Agency Response: The department does not have the authority to repeal a statutory provision by rule. Subchapter H of Insurance Code Chapter 1305 specifically requires a

network to have both utilization review and retrospective review, thereby recognizing a network's ability to engage in retrospective review. Insurance Code §1305.351 does not require that a network make use of its ability to require preauthorization of services. The network has discretion to decide which, if any, services will require preauthorization.

§10.102(f): A commenter asks if the next business day will suffice for provision of the notice of determinations in cases involving post-stabilization

Agency Response: No. Insurance Code §1305.353(f) and the rule require that notice be transmitted "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." This provision is statutorily mandated and cannot be changed to allow a delay until the next business day.

§10.102(f): A commenter requests clarification of the meaning of post-stabilization treatment and treatment involving a life-threatening condition as opposed to emergency services which do not require preauthorization. The commenter also requests clarification that preauthorization is not required should treatment become necessary outside of normal business hours and states that such treatment would remain subject to retrospective review. Another commenter suggests the removal of subsection (f) from §10.102 and the deletion of the definition of "life-threatening condition" from the utilization review section of these regulations as the commenter opines that this is a

change from what is presently required for workers' compensation utilization review agents in the state of Texas. The commenter also suggests that life-threatening conditions and post-stabilization care be reviewed retrospectively.

Agency Response: Post-stabilization treatment relates to treatment delivered immediately following emergency services where the patient has been stabilized. Emergency services are services that require immediate treatment and cannot be delayed for preauthorization, while life-threatening conditions will allow a short delay for preauthorization of proposed services. The department does not have the authority to remove subsection (f) of §10.102 because the provision is statutorily mandated in Insurance Code §1305.353. This standard is applicable to care delivered through a workers' compensation health care network without reference to any previously applicable standards that were changed by the passage of the statute.

§10.102(g): A commenter opines that the statutory deadlines set forth in Labor Code §408.027 and Insurance Code §1305.106, which give the carrier or network 45 days to audit the bill and make a determination as to whether or not utilization review is necessary, are in conflict with the provision that if the network provider requests retrospective review of medical treatment, the utilization review agent must transmit the retrospective review determination to the provider within three calendar days of the request. The commenter states that submission of a medical bill for payment of medical services not requiring preauthorization is effectively a request for retrospective review of treatment and a request for payment.

Agency Response: The department agrees and has removed the reference to "retrospective review" in proposed §10.102(g) and has added a new subsection (h) that makes the retrospective review determination deadlines consistent with the payment deadlines in Labor Code §408.027. The commenter is correct that the submission of a claim is effectively a request for retrospective review and no further request is necessary.

§10.102(g): Some commenters recommend that the person performing utilization review issue and transmit the determination no later than three “working” days rather “calendar” days; one states that the change would provide flexibility during three-day holiday weekends; and another expresses concern that providers will submit all of their bills on Fridays to preclude utilization review. Another commenter alternately requests changing the three calendar day requirement to five calendar days. Another commenter recommends allowance of only one business day for approval or denial of preauthorization requests, believing that there is sufficient profit to offset the costs of this need and that persons performing the review will fully use any time allotted.

Agency Response: The department does not have the authority to make the requested change because Insurance Code §1305.353(d) requires that preauthorization requests other than those addressed in Insurance Code §1305.353 (e) and (f) must be issued and transmitted not later than the third calendar day after the date the request is received.

§10.103(a): A commenter feels that the requirement to make available and maintain a written description of reconsideration procedures increases the exposure for the costly administrative burden to the system and recommends deleting it.

Agency Response: The department does not have the authority to delete the statutorily mandated requirements of Insurance Code §1305.354(a) in this section.

§10.103(a)(3): A commenter requests deletion of the requirement of sending an acknowledgment letter to the provider within five days of receipt of a request for reconsideration, stating that the requirement is administratively burdensome and unnecessary. Another commenter notes that there is not a similar requirement for the workers' compensation system. Another commenter states that five days is too long and requests that the acknowledgement letter instead be sent to the requesting party in two days. Another commenter opines that five days is insufficient time and requests ten days in which to provide this acknowledgment.

Agency Response: The department does not have the authority to make the requested change because the requirement is statutorily mandated in Insurance Code §1305.354(a)(3). This statutory standard is applicable to care delivered through a workers' compensation health care network without reference to any other standard for the workers' compensation system.

§10.103(a)(5): A commenter states that allowing thirty days for the person performing utilization review to notify the requesting party of the determination is too much time, instead, the commenter requests notification by the seventh business day.

Agency Response: The department does not have the authority to change the statutorily mandated requirement in Insurance Code §1305.354(a)(5).

§10.103(b)(3): Commenters request that this provision be changed to provide for no more than three working days for completion of reconsideration, with some commenters recommending an exception for a life-threatening condition, in which case the completion should not exceed one calendar day. Other commenters suggest changing the provision such that it would apply only to post-stabilization care denials, denials involving life-threatening conditions, and denials of continued hospitalization.

Agency Response: The department does not have the authority to change the statutorily mandated requirement in Insurance Code §1305.354(b).

§§10.104, 10.104(a)(2)(B) and 10.104(e): Commenters request additional language requiring that a network provide and an independent review organization consider the network's treatment guidelines as part of the independent review process outlined in §1305.355 of the statute in light of the emphasis in the proposed rules on treatment guidelines as set forth in §§10.22(19) and 10.104(a). One commenter suggests that treatment guidelines will have little value if such language is not added, and another notes that such consideration is needed for proper evaluation for quality improvement

purposes. Another commenter notes that the independent review organization should recognize that a network's treatment guidelines are just "guidelines" and are not a basis under the statute for a carrier to deny payment.

Agency Response: The department declines to make this change without providing all interested parties an opportunity to comment. The change would substantively change the rule late in the rulemaking process, which would circumvent the protections afforded by Government Code §2001.029 and require republication of the rule with another 30-day comment period before the rule could be considered for adoption. The independent review organization is not precluded from considering the treatment guidelines; however, the statute does not require the independent review organization to use the guidelines in making its determination. The carrier may not deny treatment for a compensable injury solely on the basis that the treatment under consideration is not within the treatment guidelines under §10.83(b).

§10.104: The commenter opines that 120 days should be the minimum deadline to request review by an independent review organization because of the risk that the administrative burden on the provider might drive reputable providers from the system.

Agency Response: The department does not have the authority to make the requested change because the deadlines in the rule are statutorily mandated in Insurance Code §1305.355.

§10.104(a): A commenter requests that the definition of "health care reasonably required" be incorporated into §10.104(a) making the provision applicable to a person who denies that the treatment is not in accordance with generally accepted standards of medical practice recognized in the medical community.

Agency Response: The department does not agree with the requested change because it would add the “health care reasonably required” standard to the utilization review and independent review processes. However, the “medically necessary and appropriate” standard is referenced by the statute, which indicates that Insurance Code Article 21.58A applies to utilization review in the event that there is no conflict between Article 21.58A and Chapter 1305.

§10.104(a)(2)(B): A commenter requests deletion of the requirement to provide treatment guidelines to an independent review organization, stating the requirement is excessive and may create concerns with copyright issues.

Agency Response: The department does not have the authority to make the requested change because Insurance Code §1305.355(a)(2)(B) requires the utilization review agent to provide to the independent review organization any documents used by the utilization review agent in making an adverse determination. The department declines to make the suggested change.

§10.104(g): A commenter states that the term "decision" should be replaced with the term "determination" in order to be consistent with the statutory language found in Insurance Code §§1305.355 (f) and (g).

Agency Response: The department believes that the term “decision,” as used in this subsection, is clear and does not require change. Additionally, because the independent review organization’s finding may favor the provider or injured employee, use of a different term precludes confusion with the term “adverse determination.”

§10.104(g): A commenter questions whether a carrier must pay for health care during the pendency of an appeal for judicial review where an employee appeals an independent review organization’s decision in support of denial of care, stating that such a requirement would defeat the purpose of the denial.

Agency Response: Insurance Code §1305.355(f) states that a determination of an independent review organization related to a request for preauthorization or concurrent review is binding during the pendency of the appeal. The carrier is therefore liable for the care during that time period.

§10.120: A commenter requests that the rule more specifically set forth the procedures used in processing complaints in order to ensure consistency within the system.

Agency Response: Insurance Code §1305.401(a) requires networks to implement and maintain a complaint system that provides reasonable procedures to resolve oral or written complaints. This provision in the statute allows networks the flexibility to set up

their own processes for complaint-handling. The department will monitor network complaint procedures for reasonableness and to determine if any future rulemaking is necessary.

§10.121(c): A commenter asks whether the complaint timeframes outlined in §10.121 are considered calendar days or business days.

Agency Response: Unless indicated otherwise, all references to days in the rules are calendar days. The department, however, has added the term “calendar” in proposed §10.121(c) to avoid confusion since the term “calendar” is already included in §10.121(a).

§10.121(c): A commenter asserts that 10 days is a more appropriate time frame for a network to investigate a complaint than the 30 days that §10.121(c) requires because data establishes that wasted time increases medical costs.

Agency Response: Insurance Code §1305.402(b) requires networks to investigate, as well as resolve a complaint within 30 calendar days. To maintain consistency with the statute, §10.121(c) requires networks to issue resolution letters within 30 days.

§10.121(e): Commenters request that §10.121(e) include language that requires that complaint logs be considered public knowledge available to parties under the Open Records Act. Another commenter requests that the logs should be made available within 30 days of written request.

Agency Response: The department declines to make the suggested change because the statute does not require periodic filing of the complaint log with the department. The Public Information Act is applicable to governmental bodies and not private entities. The department reviews the complaint logs during examinations. Insurance Code §1305.502 requires the annual publication of consumer report cards that include "consumer satisfaction with care" data, which may include some of the complaint log data.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS.

For with changes: Association of Fire & Casualty Insurers of Texas; American College of Occupational and Environmental Medicine; American Insurance Association; Baylor Health Care System; Beech Street Corporation; Berkstresser & Associates Rehabilitation Advisors; Case Management Solutions; Center for Orthopaedic Specialties; Concentra; Inc.; Doctors Guild of Texas; FairIsaac Corporation; First Health Group Corp.; ENCORE; Insurance Council of Texas; Liberty Mutual Group; Lubbock Diagnostic Radiology, L.L.P.; Medtronic; Office of Public Insurance Counsel; Pinnacle Anesthesia Consultants, P.A.; Property Casualty Insurers Association of America; Texas AFL-CIO; Texans for Workers' Compensation Reform and Texas Self Insurance Association; Texas Ambulatory Surgery Society; Texas Association of Business; Texas Chiropractic Association; Texas Hospital Association; Texas Medical Association; Texas Mutual Insurance Company; Texas Occupational Therapy Association, Inc.; Texas Pharmacy Association; Physical Therapy Association; The Boeing Company; Zenith

Insurance Company; State Office of Risk Management; USA Managed Care Organization; The American Accreditation Healthcare Commission/URAC; Workers Compensation Pharmacy Alliance; Work & Rehab; Injury Management Organization; and Texas Property and Casualty Insurance Guaranty Association.

Against: None.

6. STATUTORY AUTHORITY. The new sections are adopted 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 (Workers' Compensation Health Care Networks). In addition, §1305.005(i) authorizes the Commissioner of Insurance to adopt rules as necessary to implement §1305.005 (Participation in Network; Notice of Network Requirements). 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 (Complaint System Required). Section 1305.403 requires the Commissioner of Insurance to adopt rules designating the classification of network complaints under §1305.403 (Record of Complaints). 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 (Health Care Utilization Review Agents). Insurance Code §31.007 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 (Workers' Compensation Research)

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) If a court of competent jurisdiction holds that any provision of this chapter is inconsistent with any statutes of this state, is unconstitutional, or is invalid for any reason, the remaining provisions of this chapter shall remain in full effect.

(f) 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--A 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, including the physical address which the employee represented to the employer as the employee's address;

(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 or arrange 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. 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 workers' compensation health care network 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.

§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 $5,000.

(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, Mail Code 103-6A, Texas Department of Insurance, 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; and

(D) 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 projections related to anticipated revenue and profitability 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, unless the entity is already licensed by the department;

(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 obtaining certification by doctors and health care practitioners of filing 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 HMO Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, TX 78714-9104.

§10.25. Filing Requirements.

(a) A network shall file with the department as soon as practicable but not later than 30 days prior to implementation, 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 (relating to Contents of Application);

(3) material modification of network configuration; and

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

(b) A network shall file with the department any information other than the information in subsection (a) of this section that amends, supplements, or replaces the items required under §10.22 of this chapter. The information must be filed no later than 30 days after implementation of any change.

§10.26. Modifications to Service Area.

(a) A network must file a modification request 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 modification request 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 modification request by attesting to the truth and accuracy of the information in the modification request.

(b) A modification request 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 projections as described in §10.22(13) of this chapter for the existing network, the proposed new service area, and the proposed network.

(c) If a modification request for a service area changes any of the following items, the applicant must file the new item or any amendments to an existing item with the modification request 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) A modification request 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 request, 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 modification request forms may be obtained from:

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

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

§10.27. Modifications to Network Configuration.

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

(b) A modification request 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) A modification request 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 a modification request 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 modification request forms may be obtained from:

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

(2) the HMO Division, Mail Code 103-6A, Texas Department of Insurance, 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 by the commissioner in accordance with Insurance Code §1305.102.

(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, as applicable;

(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 chapter;

(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 to the extent permitted by law;

(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 reassume 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) except as provided in Insurance Code §1305.451(b)(6), 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 statement that the insurance carrier or network may not deny treatment solely on the basis that a treatment for a compensable injury in question is not specifically addressed by the treatment guidelines used by the insurance carrier or network;

(4) 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;

(5) 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 complaint resolution process under Insurance Code §§1305.401 - 1305.405 and Subchapter G of this chapter (relating to Complaints);

(6) a clause regarding appeal by the provider of termination of network provider status, except for termination due to contract expiration, and applicable written notification to employees receiving care 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 providers of the same licensure and 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;

(7) 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;

(8) 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;

(9) 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);

(10) 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;

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

(12) 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;

(13) 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; and

(14) a statement that the provider specifically agrees to provide treatment for injured employees who obtain workers' compensation health care services through the network that is specifically identified in the contract as a contracting party.

(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 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:

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

(2) the employee acknowledgment form described by Insurance Code §1305.005 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 comply with all requirements under subsection (c) – (h) of this section, as applicable.

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

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

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

(3) may be in an electronic format provided a paper version is available upon request.

(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, Mail Code 103-6A, Texas Department of Insurance, 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) must 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, other than emergency 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 where the employee lives;

(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, and a carrier required to provide employee information to an employee under Insurance Code §1305.103(c) and subsection (b) of this section shall obtain a signed employee acknowledgment form from that employee. For purposes of this subsection, an employer or carrier, as applicable, may obtain an acknowledgement of the notice required under this section through electronic means from an employee who makes an electronic signature in accordance with applicable law.

(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; and the employee may be liable, and the carrier may not be liable, for payment for health care services received out of network if it is ultimately determined that the employee lives in the network's service area;

(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 and within the time appropriate to the circumstances and

condition of the injured employee, but not later than 21 days after the date of the request.

(h) An employer or carrier, as applicable, 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, the location of the delivery, and the date or dates of delivery. The failure of an employer or carrier, as applicable, 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 the method of delivery of the notice, to whom the notice was delivered, location of delivery, 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 a 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 an intentional 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 and service area under Insurance Code §1305.005 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 a 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 described at §10.22(18) of this chapter (relating to Contents of Application) shall be filed with the department in accordance with §10.21 of this chapter (relating to Certificate Application) and 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 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 skilled or specialty care 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 a 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 and provider payment 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);

(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.

(g) Until January 1, 2007, non-certified case managers may assist in providing the required medical case management services. The non-certified case managers must have prior experience in one of the areas delineated in subsection (f)(1) – (6) of this section, and may not serve as claim adjusters. The non-certified case managers must be under the direct supervision of a certified case manager as described in subsection (f) of this section at all times.

§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.

Procedures shall include certification by applicants of completion of required maximum medical improvement and impairment rating training and filing of financial disclosure in accordance with Labor Code §§408.023 and 413.041. The credentialing criteria and procedures must be made available to network providers or applicants upon request.

(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;

(ll) 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;

(lll) students, residents, or fellows;

(lV) 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:

(l) 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;

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

(lll) 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. 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.

(lll) 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.

(lV) 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:

(l) 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

(ll) 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.

(vi) A network may phase in the required site visits to treating doctors until not later than the first anniversary after the date of the network's certification. If the department receives a complaint about a treating doctor who has not had a site visit, the network shall perform a site visit not later than 30 days after

notification by the department of the complaint unless circumstances warrant an immediate site visit, and shall take action to correct any deficiencies found.

(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 health care facilities shall include the following:

(i) evidence of state licensure;

(ii) evidence of Medicare certification;

(iii) evidence of compliance with 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 State Health Services 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 health care facilities. The network's written policies and procedures must state which national accrediting bodies it accepts; and

(v) evidence of on-site evaluation of the health care facility 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 health care facilities 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 one of the national accreditation organizations as described in §10.81(c) of this subchapter (relating to Quality Improvement Program), the annual audit of that entity is not required for the function(s) listed in the accreditation; however, evidence of this accreditation shall be made available to the department for review.

(3) The network shall maintain and shall make available for the department to review:

(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.

(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 accessible 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 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 injured employee required to receive health care services within a

network may select as the employee's treating doctor a doctor who the employee selected, prior to injury, as the employee's primary care physician or provider under Chapter 843, as the terms "physician" and "provider" are defined in that chapter. The network shall grant an 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, as applicable to treating doctors.

§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 and retrospective review program must include a process for a treating doctor or specialist to request approval from the network for deviation from the treatment guidelines, return-to-work guidelines, 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;

(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, the person performing utilization 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) For adverse determinations made pursuant to retrospective review, the adverse determination must be issued in response to a claim for payment consistent with the timelines set forth in Labor Code §408.027 related to payment of health care providers. An adverse determination issued under this subsection must comply with all applicable requirements related to adverse determinations in this section.

(i) 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, Mail Code 103-6A, Texas Department of Insurance, 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(i) 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.

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 calendar 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, Mail Code 103-6A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104.

CERTIFICATION. This agency certifies that the adopted sections have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on _____, 2005.

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

IT IS THEREFORE THE ORDER of the Commissioner of Insurance that 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, concerning workers' compensation health care networks, are adopted.

AND IT IS SO ORDERED.

_____
MIKE GEESLIN
COMMISSIONER OF INSURANCE

ATTEST:

_____
Gene C. Jarmon
General Counsel and Chief Clerk

COMMISSIONER'S ORDER NO._____