Chapter 10. Workers' Compensation Health Care Networks

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INTRODUCTION. The Texas Department of Insurance (TDI) proposes to repeal §10.102 and §10.103, to reflect that retrospective reviews are now included in utilization review. TDI also proposes to add new §10.3 and to amend the following sections in 28 TAC Chapter 10, concerning workers' compensation health care networks: Subchapter A, §10.1 and §10.2; Subchapter B, §§10.20 - 10.27; Subchapter C, §§10.40 - 10.42; Subchapter D, §§10.60 - 10.63; Subchapter E, §§10.80 - 10.86; Subchapter F, §§10.100, 10.101, and 10.104; Subchapter G, §§10.120 - 10.122; and Subchapter H, §10.200.

EXPLANATION. The proposed new section, amendments, and repeals in Chapter 10 implement legislative amendments to the Insurance Code. Some of the proposed amendments implement changes to Insurance Code Chapter 1305, as added by House Bill (HB) 7, 79th Legislature, 2005; and as amended by HB 4290, 81st Legislature, 2009; Title 5 of the Labor Code, as amended by HB 7 and HB 4290; and Occupations Code Chapter 111, as amended by Senate Bill (SB) 1107, 85th Legislature, 2019, and HB 2056, 87th Legislature, 2021. The proposal also removes unnecessary data requirements, reducing the burden on workers' compensation health care networks (certified networks) and carriers. In addition, the amendments and repeals harmonize certified network requirements with rules for other networks and utilization review requirements to comply with Insurance Code Chapter 4201, concerning Utilization and Independent Review, which was recodified and amended since Chapter 10 was adopted. In general, recent updates to Utilization Review Agent rules in Chapter 19 also apply to certified networks, so conforming edits to Chapter 10 decrease rule redundancy. The proposed amendments update current rules to correct obsolete statutory citations and physical address references, shorten some rules with simpler citations to statutes or references to other rules, and comply with current TDI language preferences and drafting practices.

The proposed new rule and amendments to specific sections are described in the following paragraphs, organized by subchapter.

Subchapter A. General Provisions and Definitions.

Section 10.1. The proposed amendments to §10.1 update and add more complete statutory citations; reflect the addition of Insurance Code §1305.008 by HB 472, 80th Legislature, 2007; remove a 2006 applicability date; and make changes to conform to current TDI language preferences and drafting practices.

Section 10.2. The proposed amendments to §10.2 update and add more complete statutory citations, clarify existing and add new definitions, and make changes to conform

to current TDI language preferences and drafting practices. Specifically, the proposed amendments:

- update the definition of "adverse determination" to clarify that the term does not include a denial of health care services because of a failure to request prospective or concurrent utilization review;

- provide, under Labor Code §413.014(a) and 28 TAC §134.600, that certified networks are not allowed to deny services because they are experimental or investigational;

- add definitions of "administrator," "concurrent utilization review," "Division of Workers' Compensation," "MCQA," "physician," and "telehealth service, telemedicine medical service, and teledentistry dental service;"

- amend the definitions of "affiliate," "capitation," "complainant," "complaint," "credentialing," "emergency," "fee dispute," "independent review," "independent review organization," "medical emergency," "medical records," "mental health emergency," "network or workers' compensation health care network," "person," "quality improvement program," "rural area," "screening criteria," and "transfer of risk" to cite Insurance Code §1305.004 rather than repeat its provisions;

- amend the definition of "life threatening" to cite Insurance Code Chapter 4201;

- remove the definition of "nurse" because the term is no longer used in the rule;

- amend the definition of "preauthorization" to remove a separate reference to retrospective review, because the definition of "utilization review" in Insurance Code §1305.004 refers to the definition in Insurance Code Chapter 4201, which includes retrospective review, and the 2009 amendments to Insurance Code Chapter 1305 by HB

4290 removed separate references to retrospective review in sections referring to utilization review;

- amend the definition of "retrospective review" to exclude the review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted because preauthorization no longer includes retrospective review and retrospective review does not include preauthorization or concurrent review;

- amend the definition of "service area" to clarify that the service area is the area approved by TDI; and

- amend the definitional adoption of the meanings assigned by Labor Code §401.011 to include "impairment rating" and "maximum medical improvement."

Section 10.3. Proposed new §10.3 indicates that any contact information needed for the Division of Workers' Compensation or the Office of Managed Care Quality Assurance can be found on TDI's website and notes that this contact information should be used when an email address, mailing address, or telephone number is referenced in Chapter 10.

Subchapter B. Certification.

Section 10.20. The proposed amendments to §10.20 add more complete statutory citations and remove a reference to "contracting with more than one person" from the description of a person who must be certified as a workers' compensation health care network, because this language is not contained in Insurance Code Chapter 1305.

Section 10.21. The proposed amendments to §10.21 remove a specific web address and a specific mailing address contained in the section to avoid providing incorrect information should that address change.

Section 10.22. The proposed amendments to §10.22 add more complete statutory citations and make changes to conform to current TDI language preferences and drafting practices. In addition, the proposed amendments:

- specify submission of the National Association of Insurance Commissioners Uniform Certificate of Authority Application (NAIC UCAA) Form 11 biographical affidavit for providing biographic data;

- clarify that a description and map of the applicant's proposed service area is required and require a map with information for each specialty providing services to injured employees in order to simplify applications and shorten processing times by eliminating delays when TDI has to request these materials;

- require information about providers that provide telehealth service, telemedicine medical service, or teledentistry dental services so TDI can discover who is providing services by telecommunications or other information technology and how that affects certified networks, as well as what services are available by telecommunications or other information technology and whether those services can actually be provided in that manner;

- clarify that an access plan is required for any service area in which the certified network does not meet accessibility and availability requirements, to simplify applications and shorten processing times by eliminating delays when TDI must request the necessary access plans; and

- clarify that applicants must verify that certified network doctors have completed both training and testing as required by the Labor Code and rules adopted by the Commissioner of Workers' Compensation.

Section 10.23. The proposed amendments to §10.23 add more complete statutory citations and make changes to conform to current TDI language preferences and drafting practices.

Section 10.24. The proposed amendments to §10.24 add more complete statutory citations, remove a specific mailing address contained in the section and reference an email address instead to avoid providing incorrect information should that mailing address change, and make changes to conform to current TDI language preferences and drafting practices.

Section 10.25. The proposed amendments to §10.25 add more complete statutory citations and make changes to conform to current TDI language preferences and drafting practices. The proposed amendments also:

- refer to §10.27 in regard to material modifications;

- clarify that a certified network must file an expansion, elimination, or reduction of an existing service area, or addition of a new service area, with TDI for approval before implementation and in accordance with the prior approval requirement in §10.26; and

- add a requirement that a certified network notify TDI of the merger of the certified network with another entity and any other organizational change at least 30 days before implementing the merger or organizational change.

Section 10.26. The proposed amendments to §10.26 add more complete statutory citations and make changes to conform to current TDI language preferences and drafting practices. In addition, the proposed amendments:

- remove a 30-day advance filing requirement for modification requests as duplicative of the requirement for prior approval;

- add statutory citations and references to rules with which a corrected notice of certified network requirements and employee information and acknowledgment form must comply; and

- remove a specific mailing address contained in the section to avoid providing incorrect information should that address change.

Section 10.27. The proposed amendments to §10.27 add more complete statutory citations and make changes to conform to current TDI language preferences and drafting practices. Also, the proposed amendments:

- remove specific email and mailing addresses contained in the section to avoid providing incorrect information should the addresses change;

- add a requirement that a request for a modification to network configuration that adds or modifies telehealth service, telemedicine medical service, or teledentistry dental service must include an explanation about updating its provider directory and any statements or restrictions on those services in the request; and

- in response to continued questions from regulated entities, clarify that a material modification includes a change to the network configuration that alters the ability of the certified network to comply with the availability and accessibility requirements described in §10.80.

Subchapter C. Contracting.

Section 10.40. The proposed amendments to §10.40 add more complete statutory citations and make a change to conform to current TDI language preferences and drafting practices. Amendments also clarify that a person serving as both a management contractor or a third party and as an agent of the health care provider must comply with Insurance Code §1305.153.

Section 10.41. The proposed amendments to §10.41 add more complete statutory citations and make changes to conform to current TDI language preferences and drafting practices. The proposed amendments also:

- provide that, except for emergencies and out-of-network referrals, a certified network may provide health care services to employees only through a written contract with an insurance carrier, to conform to Insurance Code §1305.154(a);

- refer to both the carrier's and the certified network's responsibility for delegated functions, to conform to Insurance Code §1305.154(b);

- require reporting of claim numbers, which are already available and being reported, so that TDI will know how many claims are actually affected;

- remove a separate reference to retrospective review because retrospective review is included in utilization review;

- correct a typographical error; and

- require certified network consent to subdelegation of network functions to avoid situations where networks are unaware of subdelegations or where there is no monitoring of subdelegations.

Section 10.42. The proposed amendments to §10.42 add more complete statutory citations and make changes to conform to current TDI language preferences and drafting practices. The proposed amendments also require provider contracts to provide that:

- the provider agrees to follow the pharmacy closed formulary adopted by the Division of Workers' Compensation under 28 TAC §134.540 so TDI can be assured that contracted providers are aware of and compliant with this existing requirement;

- billing and payment will be made in accordance with rules governing the billing and payment for certifications of maximum medical improvement and impairment rating examinations so TDI can ensure that providers and certified networks are aware of and compliant with these existing requirements;

- the provider will receive written notice from the carrier if the carrier contests compensability of an injury the provider is treating, to conform to Insurance Code §1305.154(e); and

- the carrier may not deny payment for services provided prior to the issuance of the notice on the grounds that the injury was not compensable, to conform to Insurance Code §1305.154(e).

Subchapter D. Network Requirements.

Section 10.60. The proposed amendments to §10.60 add more complete statutory citations and make changes to conform to current TDI language preferences and drafting practices. In addition, the proposed amendments:

- provide that the employer and carrier must determine whether the employer or carrier will be responsible for obtaining a signed employee acknowledgment form from each employee and delivering notices to employees, and generally substitute the term "responsible party chosen under subsection (g)" for references to the carrier and employer regarding notifications;

- provide that, upon notification that health care services are being provided through the network, an employee living 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 that network, may select a network treating doctor from a list of contracted doctors or request a doctor who the employee selected, prior to the injury, as the employee's primary care physician or provider under Insurance Code Chapter 843;

- remove the Health Maintenance Organization Division mailing address from the list of places from which a sample acknowledgment form may be obtained because there is no longer a program area named "Health Maintenance Organization Division";

- provide that the employer and carrier must determine and agree which of the two will be responsible for obtaining a signed employee acknowledgment form from each employee, must document the parties' agreement, and must make the documentation available to TDI and the Division of Works' Compensation upon request, to clarify requirements and allow for the carrier and employer to determine the responsible party and ensure that documentation of that determination is maintained;

- revise language regarding retaliation to reflect the language of Insurance Code §1305.404;

- require the clear identification of providers who provide telehealth or telemedicine medical services in lists of certified network providers so it will be clear to injured employees, providers, certified networks, and TDI who is providing these services;

- clarify that the failure of the "responsible party" to establish a standardized process for complying with the delivery of notice of network requirements in this section creates a rebuttable presumption that the employee has not received the notice and is not subject to network requirements;

- require the "responsible party" to maintain copies of the notice of certified network requirements and employee information and the signed employee acknowledgment form for each employee and allow these to be maintained electronically, but the responsible party must be able to provide evidence that the notice was provided to and acknowledged by the employee; and

- provide that a dispute regarding whether an employer or carrier properly provided the information required by this section to an employee may be resolved by requesting a benefit review conference to conform to Insurance Code §1305.103 and §1305.451.

Section 10.61. The proposed amendments to §10.61 add more complete statutory citations and make changes to conform to current TDI language preferences and drafting practices. The proposed amendments also:

- add a reference to the rules of the Division of Workers' Compensation to provide guidance regarding treatment for compensable injuries to non-network providers; and

- eliminate subsection (d) because it is not necessary in light of Insurance Code §1305.005(b).

Section 10.62. The proposed amendments to §10.62 make changes to conform to current TDI language preferences and drafting practices.

Section 10.63. The proposed amendments to §10.63 add more complete statutory citations and make changes to conform to current TDI language preferences and drafting practices.

Subchapter E. Network Operations.

Section 10.80. The proposed amendments to §10.80 make changes to conform to current TDI language preferences and drafting practices. The proposed amendments also:

- clarify that providers must be licensed to practice in this state, unless exempt from licensing requirements;

- clarify that network adequacy is measured by the number of contracting doctors and specialists, not noncontracted ones;

- replace a requirement to give the reason or reasons that health care services or providers cannot be made available for each geographic area identified as not having adequate health care services or providers available with requirements to list the providers or physicians a certified network attempted to contract with, how and when the certified network contacted each provider, and a description of a reason each provider gave for declining to contract with the certified network to more closely track 28 TAC §3.3707, because these descriptions have resulted in better reporting by carriers and better oversight by TDI;

- remove duplicative requirements in current §10.80(g)(4)(B) and (C), which are already included in §10.80(f) and proposed new (g)(6); and

- provide specific reporting requirements in §10.80(g)(5) when a general hospital is not available in an approved nonrural county, or a general acute hospital is available in an approved nonrural area but refuses to contract with the certified network.

Section 10.81. The proposed amendments to §10.81 add more complete statutory citations and make changes to conform to current TDI language preferences and drafting practices. In addition, the proposed amendments:

- remove a separate reference to retrospective review because a statutory change since the creation of the rule added retrospective review to the definition of utilization review;

- require certified networks to maintain documentation demonstrating that doctors who provide certifications of maximum medical improvement or assign impairment ratings to injured employees are authorized to do so under 28 TAC §130.1; and

- remove a now-obsolete subsection (g), dealing with actions permitted until January 1, 2007.

Section 10.82. The proposed amendments to §10.82 make changes to conform to current TDI language preferences and drafting practices. The proposed amendments also:

- substantially shorten the section, simplify the process for selection and retention of preferred providers, and make the process more cost effective by replacing lengthy and detailed credentialing requirements with nationally promulgated processes;

- reduce certified network effort and inquiries by including a reminder that requirements of §10.41 apply to delegation of credentialing; and

- allow time for compliance with the new amendments by permitting entities subject to §10.82 to comply with the section as it currently exists until September 23, 2022; entities will have until September 23, 2022, to make a filing attesting to compliance with the rule amendments;

Section 10.83. The proposed amendments to §10.83 make changes to conform to current TDI language preferences and drafting practices.

Section 10.84. The proposed amendments to §10.84 add more complete statutory citations and make changes to conform to current TDI language preferences and drafting practices.

Section 10.85. The proposed amendments to §10.85 add more complete statutory citations and make changes to conform to current TDI language preferences and drafting practices.

Section 10.86. The proposed amendment to §10.86 makes a change to conform to current TDI language preferences and drafting practices.

Subchapter F. Utilization Review and Retrospective Review.

The proposed amendments drop "and Retrospective Review" from the title of the subchapter because a statutory change since the creation of the subchapter added retrospective review to the definition of utilization review.

Section 10.100. The proposed amendments to §10.100 correct obsolete citations and add more complete statutory citations.

Section 10.101. The proposed amendments to §10.101 make changes to conform to current TDI language preferences and drafting practices. The proposed amendments also:

- remove separate references to retrospective review because retrospective review is a part of utilization review;

- add new subsections (c) and (d) to address Labor Code §§408.0043 - 408.0045 requirements relating to qualifications for utilization review reviewers and track the language currently used in the utilization review agent rules;

- add new subsection (e) to clarify the requirements that apply to health care providers through a certified network, as authorized by Labor Code §413.014;

- add new subsection (f) to shorten and simplify the rule by referring to the requirements of Insurance Code Chapter 1305 and 28 TAC Chapter 19, Subchapter U,

rather than repeating the requirements of these statutes and rules in §10.102 and §10.103; and

- add new subsection (g) to include a requirement that reconsideration procedures must include a method for expedited reconsideration under Insurance Code §1305.354(b) and (c).

Section 10.102 and §10.103. Section 10.102 and §10.103 are proposed for repeal. The general standards for utilization review addressed in those sections are replaced with new subsections proposed in §10.101.

Section 10.104. The proposed amendments to §10.104 update obsolete statutory citations, add more complete statutory citations, and make changes to conform to current TDI language preferences and drafting practices. In addition, the proposed amendments:

- insert references to Insurance Code Chapter 1305, Subchapter H, and TDI and Division of Workers' Compensation rules to aid in compliance;

- reformat and redesignate some subsections of the rule;

- remove separate references to retrospective review because retrospective review is now included in the definition of utilization review;

- update a reference to conform to the redesignation of subsections;

- shorten and simplify the rule by citing Insurance Code §1305.354(a)(4) and 28 TAC §133.308(k) rather than listing requirements previously contained in §10.104(b)(2)(A) - (E);

- add new subsection (g) to conform to Labor Code §413.0311; and

- note, for the convenience of participants, that TDI and the Division of Workers' Compensation are not considered to be parties to a medical dispute.

Subchapter G. Complaints.

Section 10.120. The proposed amendments to §10.120 make changes to the section to conform to current TDI language preferences and drafting practices and

provide clarity to providers and certified networks by clarifying that a complaint relating to a fee dispute is a complaint from a provider regarding the certified network's failure to pay a claim in accordance with the contract between the certified network and provider.

Section 10.121. The proposed amendments to §10.121 make changes to conform to current TDI language preferences and drafting practices. The proposed amendments also:

- require resolution letters to explain the certified network's procedures and deadlines for filing an appeal of the complaint;

- require the maintenance of a complaint-and-appeal log because a record of complaints is more useful if a record of appeals is included; and

- remove a reference to retrospective review.

Section 10.122. The proposed amendments to §10.122 remove specific email addresses contained in the section to avoid providing incorrect information if the addresses change. The amendments also add a provision stating that the complaint form may be obtained from TDI's website.

Subchapter H. Examinations.

Section 10.200. The proposed amendments to §10.200 add more complete statutory citations, make changes to conform to current TDI language preferences and drafting practices, and make revisions to eliminate confusion among regulated entities by clarifying that examination fees are payable to TDI at the address shown on the invoice.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Debra Diaz-Lara, associate commissioner, Life and Health Division, has determined that during each year of the first five years that the proposed new section, amendments, and repeals are in effect, there will be no fiscal impact on state or local government as a result of enforcing or administering them. Ms. Diaz-Lara made this determination because the proposal does

not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed new section and amendments.

Ms. Diaz-Lara does not anticipate a measurable effect on local employment or the local economy as a result of the proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed new section, amendments, and repeals are in effect, Ms. Diaz-Lara expects that administering them will have the public benefit of (1) implementing legislative amendments to relevant portions of the Insurance and Labor Codes; (2) removing unnecessary data requirements, which will reduce the burden on certified networks and carriers; (3) lessening administrative costs by harmonizing workers' compensation network requirements with rules for other networks and utilization review requirements to comply with Insurance Code Chapter 4201; and (4) simplifying Chapter 10 by decreasing rule redundancy and shortening some rules with simpler citations to statutes.

Ms. Diaz-Lara expects that the proposal will impose initial economic costs to certified networks in order to implement the expanded maintenance and reporting requirements mandated by the proposed amendments, but that the reduction of administrative burden on certified networks will more than offset any initial costs, resulting in an overall reduction in costs for compliance with the rule. The initial cost will involve compliance requirements for certified networks, including the maintenance of additional copies of certain documents under §§10.60, 10.81, and 10.121, and certain other certified network information (e.g., maps for each specialty providing services and information regarding providers that offer telehealth service, telemedical services, or teledentistry services), and including requirements for two filings: a one-time filing in §10.82(d), regarding an attestation of compliance of the new amendments by a certain

date, and a potential filing regarding the merger or organizational change of a certified network in §10.25(d). However, due to technological advancements since Chapter 10 was most recently amended, it is likely that certified networks are already collecting the additional data elements and maintaining certain documents that these rules would now require.

TDI anticipates that at least three temporary employees will be necessary to implement the maintenance and reporting changes in §§10.22, 10.60, 10.81, and 10.121, two employees to review and revise current internal procedures, and one employee to implement newly required internal processes, but that estimate could vary depending on each certified network's internal processes and needs. It is not feasible for TDI to ascertain the actual cost to comply with the proposed amendments; certified networks are better suited to determine them. The exact method of compliance is a business decision, including the decision about whether to employ current staff, hire new staff, or contract for some of these services. Further, every certified network has unique internal processes, resources, and technical capabilities.

Though costs to each certified network will depend on the volume and degree of complexity of their internal processes, TDI estimates the following possible needs: individual employee compensation for an administrative assistant at $16.82 per hour and a training and development manager at $55.51 per hour for one to 20 hours of work to revise an insurer's internal procedures. TDI also estimates individual employee compensation for an administrative assistant at $16.82 per hour for one to 30 hours to implement newly required internal processes, such as maintaining complaint logs, and to submit newly required forms and documentation. These wages are based on the latest State Occupational Employment and Wage Estimates for Texas published by the U.S. Department of Labor (May 2019) at www.bls.gov/oes/current/oes_tx.htm.

The proposal also eliminates several burdensome requirements for certified networks, offsetting the costs any new requirements might create. These include streamlining the standards for utilization review in §10.101; removing a 30-day advance filing requirement for modification requests in §10.26; clarifying what constitutes a "material modification" to network configuration in §10.27, which may reduce reporting of extraneous information; and streamlining other sections to eliminate confusion or other outdated burdens on the networks. This proposal also includes cost-saving amendments to Chapter 10, further offsetting costs any new requirements may create. These include:

- adding a new contract provision requirement in §10.41 for a certified network's delegate to obtain the network's consent to subdelegation of network functions, which will prevent situations where networks are unaware of and do not monitor subdelegations;

- reducing the risk of liability and associated costs a network would face in such a situation;

- changing the required contents of a certified network's access plan in §10.80 to clarify the requirements and remove indefinite standards, which will save networks time in developing an access plan; and

- eliminating costly and complicated credentialing requirements in §10.82, replacing them with nationally promulgated processes, which will reduce the burden on certified networks by allowing them to develop or adopt processes that best meet their needs in selecting and retaining credentialed providers.

Once certified networks have updated internal processes and forms for compliance, the additional new costs for certified networks will become minimal, if any. This proposal does not add any new recurring filings--only a one-time-filing requirement in §10.82(d), regarding an attestation of compliance of the new amendments by a certain date, and a potential filing regarding the merger or organizational change of a network

in §10.25(d). Once the requirements of the proposed amendments are implemented, any recurring costs for a certified network will be consistent with the recurring costs that result from current requirements.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the proposal may have an adverse economic effect on small or micro businesses, but not on rural communities. The cost analysis in the Public Benefit and Cost Note section of this proposal also applies to these small and micro businesses and rural communities for purposes of this economic impact statement and regulatory flexibility analysis. TDI estimates that the proposed amendments and repeals may affect approximately five small or micro businesses.

The primary objectives of this proposal are to implement legislative amendments to the Insurance Code, remove unnecessary data requirements to reduce the burden on certified networks, and harmonize certified network requirements with rules for other networks and utilization review requirements.

The other regulatory methods considered by TDI to accomplish the objectives of the proposal and to minimize any adverse impact on small and micro businesses include (1) not proposing amendments to Chapter 10, (2) implementing different requirements or standards for small and micro businesses, and (3) excluding small and micro businesses from applicability under the proposed amendments.

Not proposing amendments to Chapter 10. If the new section and amendments were not proposed, certified networks, including those that are small or micro businesses, would continue to have trouble reconciling differences between the statutes and rules, which could make it difficult to determine when to submit certain filings, what information to submit with a filing, and what is included within the duties of a certified network. TDI rejected this approach because it would not accomplish the objective of implementing

legislative amendments to the Insurance Code. In addition, unnecessary data requirements would remain in the rules, and the rules would continue to be inconsistent with rules for other networks and utilization review requirements.

Implementing different requirements or standards for small and micro businesses. If the proposed amendments imposed less burdensome requirements on small or micro businesses than those currently proposed requirements that have a potential economic impact, small or micro businesses would not experience the economic impacts described in this proposal. However, such exemptions would go against the legislative changes to Insurance Code Chapter 1305, Title 5 of the Labor Code, and Occupations Code Chapter 111. The Legislature did not exclude any certified networks from the statutory changes. Additionally, creating separate requirements for different certified networks based on the size of their business would be confusing for the certified networks and other participants in the workers' compensation system. TDI rejected this approach because there is not a legislative basis to propose rules that exclude small and micro businesses from the statutory changes, and because establishing a confusing system of rules would be contrary to the purpose of this proposal--to reduce the burden on certified networks and harmonize certified network requirements with rules for other networks and utilization review requirements.

Excluding small and micro businesses from applicability under the proposed amendments. If the proposed amendments excluded small or micro businesses from applicability, small or micro businesses would not experience the economic impacts described in this proposal. However, as with limited exemptions as addressed in the previous option, exempting small or micro businesses from the amendments completely would also go against the legislative intent of changes to Insurance Code Chapter 1305, Title 5 of the Labor Code, and Occupations Code Chapter 111. The Legislature did not exclude any workers' compensation health care networks from the statutory changes.

Additionally, creating separate requirements in this way for different certified networks based on the size of their business would also be confusing for the certified networks and other participants in the workers' compensation system. TDI rejected this approach because there is not a legislative basis to propose rules that totally exclude small and micro businesses from the statutory changes, and because establishing a confusing system of rules would be contrary to the purpose of this proposal--to reduce the burden on certified networks and harmonize certified network requirements with rules for other networks and utilization review requirements.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that while parts of this proposal may impose an initial cost on regulated persons, these initial costs will be more than offset by savings resulting from other parts of the proposal that reduce the regulatory burden on certified networks. Furthermore, some of the proposed amendments are necessary to implement legislation, as discussed in the following paragraph, while others reduce the burden or responsibilities imposed on regulated persons. Therefore, no additional rule repeals or amendments are required under Government Code §2001.0045.

Some of the proposed amendments implement changes to Insurance Code Chapter 1305, as added by HB 7, 79th Legislature, 2005; and as amended by HB 4290, 81st Legislature, 2009; Title 5 of the Labor Code, as amended by HB 7 and HB 4290; and Occupations Code Chapter 111, as amended by SB 1107, 85th Legislature, 2019, and HB 2056, 87th Legislature, 2021.

GOVERNMENT GROWTH IMPACT STATEMENT. TDI has determined that for each year of the first five years that the proposed new section, amendments, and repeals are in effect, the proposed new section, amendments, and repeals:

- will not create or eliminate a government program;

- will not require the creation of new employee positions or the elimination of existing employee positions;

- will not require an increase or decrease in future legislative appropriations to the agency;

- will not require an increase or decrease in fees paid to the agency;

- will create a new regulation;

- will expand, limit, or repeal an existing regulation;

- will increase the number of individuals subject to the rules' applicability; and

- will not positively or adversely affect the Texas economy.

TAKINGS IMPACT ASSESSMENT. TDI has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on March 7, 2022. Send your comments to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC-GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

To request a public hearing on the proposal, submit a request before the end of the comment period to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC-GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030. The request for public hearing must be separate from any comments and received by the TDI

no later than 5:00 p.m., central time, on March 7, 2022. If TDI holds a public hearing, TDI will consider written and oral comments presented at the hearing.

SUBCHAPTER A. GENERAL PROVISIONS AND DEFINITIONS
28 TAC §§10.1 - 10.3

STATUTORY AUTHORITY. The amendments to §10.1 and §10.2 and new §10.3 are proposed under Insurance Code §§1305.007, 4201.003, and 36.001.

Insurance Code §1305.007 provides that the Commissioner may adopt rules as necessary to implement Chapter 1305, concerning Workers' Compensation Health Care Networks.

Insurance Code §4201.003 provides that the Commissioner may adopt rules as necessary to implement Chapter 4201, concerning Utilization Review Agents.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §10.1 and §10.2 and proposed new §10.3 implement Insurance Code Chapter 1305.

TEXT.

§10.1. Purpose and Scope.

(a) This chapter implements provisions of the Workers' Compensation Health Care Network Act, Insurance Code Chapter 1305, concerning Workers' Compensation Health Care Networks, 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, concerning Self-Insurance Regulation;

(3) groups of employers certified to self-insure under Labor Code Chapter 407A, concerning Group Self-Insurance Coverage; and

(4) except as described in subsection (d) of this section, governmental entities that self-insure, either individually or collectively, under:

(A) Labor Code Chapter 501, concerning Workers' Compensation Insurance Coverage for State Employees, Including Employees Under the Direction or Control of the Board of Regents of Texas Tech University;

(B) Labor Code Chapter 502, concerning Workers' Compensation Insurance Coverage for Employees of the Texas A&M University System and Employees of Institutions of the Texas A&M University System;

(C) Labor Code Chapter 503, concerning Workers' Compensation Insurance Coverage for Employees of the University of Texas System and Employees of Institutions of the University of Texas System;

(D) Labor Code Chapter 504, concerning Workers' Compensation Insurance Coverage for Employees of Political Subdivisions; and

(E) Labor Code Chapter 505, concerning Workers' Compensation Insurance Coverage for Employees of Texas Department of Transportation [~~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 title [~~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, concerning General Definitions, that establishes or contracts with a workers' compensation health care network.

(c) A person that performs the functions of an administrator for an insurance carrier under Insurance Code Chapter 1305 must hold a certificate of authority under Insurance Code Chapter 4151, concerning Third-Party Administrators.

(d) [~~(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, concerning Interlocal Cooperation Contracts, 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), concerning Workers' Compensation Insurance Coverage for Employees of Political Subdivisions [~~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~~].

(e) [~~(d)~~] This chapter does not authorize a workers' compensation insurance policyholder, including a policyholder who purchases a deductible plan under Insurance Code Chapter 2053, Subchapter E, concerning Optional Deductible Plans, [~~Article 5.55C~~] to contract directly with a workers' compensation health care network for the provision of health care services to injured employees.

(f) [~~(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) Administrator--Has the meaning assigned by Insurance Code §4151.001, concerning Definitions.

(2) Adverse determination--A determination by a URA made on behalf of a payor that the health care services provided or proposed to be provided to an injured employee are not medically necessary or appropriate. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. For the purposes of this subchapter, an adverse determination does not include a determination that health care services are experimental or investigational [~~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~~].

(3) [~~(2)~~] Affiliate--Has the meaning assigned by Insurance Code §1305.004, concerning Definitions. [~~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.~~]

(4) [~~(3)~~] Capitation--Has the meaning assigned by Insurance Code §1305.004. The term includes predetermined payment to cover the average costs of services for a defined episode of care. [~~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.~~]

(5) [~~(4)~~] Complainant--Has the meaning assigned by Insurance Code §1305.004. [~~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.~~]

(6) [~~(5)~~] Complaint--Has the meaning assigned by Insurance Code §1305.004. [~~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.~~]

(7) Concurrent utilization review--A form of utilization review for ongoing health care or for an extension of treatment beyond previously approved health care.

(8) [~~(6)~~] Credentialing--Has the meaning assigned by Insurance Code §1305.004. [~~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.~~]

(9) Division of Workers' Compensation--Has the meaning assigned by Labor Code §401.011, concerning General Definitions.

(10) [~~(7)~~] Emergency--Has the meaning assigned by Insurance Code §1305.004. [~~Either a medical or mental health emergency.~~]

(11) [~~(8)~~] Employee--Has the meaning assigned by Labor Code §401.012, concerning Definition of Employee.

(12) [~~(9)~~] Fee dispute--Has the meaning assigned by Insurance Code §1305.004. [~~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.~~]

(13) [~~(10)~~] HMO--A health maintenance organization licensed and regulated under Insurance Code Chapter 843, concerning Health Maintenance Organizations.

(14) [~~(11)~~] Independent review--Has the meaning assigned by Insurance Code §1305.004 [~~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~~].

(15) [~~(12)~~] Independent review organization--Has the meaning assigned by Insurance Code §1305.004 [~~An entity that is certified by the commissioner to conduct independent review under Insurance Code Article 21.58C and rules adopted by the commissioner~~].

(16) [~~(13)~~] Life-threatening--Has the meaning assigned by Insurance Code Chapter 4201, concerning Utilization Review Agents [~~Article 21.58A §2~~].

(17) [~~(14)~~] Live or lives--Where an employee lives includes:

(A) the employee's principal residence for legal purposes, including the physical address that [~~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.

(18) MCQA--The Office of Managed Care Quality Assurance, or a successor office at the department.

(19) [~~(15)~~] Medical emergency--Has the meaning assigned by Insurance Code §1305.004. [~~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.~~]

(20) [~~(16)~~] Medical records--Has the meaning assigned by Insurance Code §1305.004. [~~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.~~]

(21) [~~(17)~~] Mental health emergency--Has the meaning assigned by Insurance Code §1305.004. [~~A condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.~~]

(22) [~~(18)~~] Network or workers' compensation health care network--Has the meaning assigned by Insurance Code §1305.004. [~~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.~~]

(23) [~~(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.

(24) [~~(21)~~] Person--Has the meaning assigned by Insurance Code §1305.004 [~~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~~].

(25) Physician--Has the meaning assigned by Insurance Code §4201.002, concerning Definitions.

(26) [~~(22)~~] Preauthorization--A form of prospective utilization review by a payor or a payor's URA of health care services proposed to be provided to an injured employee [~~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~~].

(27) [~~(23)~~] Provider--A health care provider.

(28) [~~(24)~~] Quality improvement program--Has the meaning assigned by Insurance Code §1305.004. [~~A system designed to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions.~~]

(29) [~~(25)~~] Retrospective review--A form of utilization review for health care services that have been provided to an injured employee. Retrospective review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted [~~The process of reviewing the medical necessity and reasonableness of health care that has been provided to an injured employee~~].

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

(31) [~~(27)~~] Rural area--Has the meaning assigned by Insurance Code §1305.004.

[~~(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~~.

(32) [~~(28)~~] Screening criteria--Has the meaning assigned by Insurance Code §1305.004. [~~The written policies, medical protocols, and treatment guidelines used by an insurance carrier or a network as part of utilization review or retrospective review.~~]

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

(34) Telehealth service, telemedicine medical service, and teledentistry dental service--Have the meanings assigned by Occupations Code §111.001, concerning Definitions.

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

[~~(31)~~] Transfer of risk--Has the meaning assigned by Insurance Code §1305.004. [~~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.~~]

(36) [~~(32)~~] Utilization review--Has the meaning assigned by Insurance Code Chapter 4201 [~~Article 21.58A §2~~].

(37) [~~(33)~~] Utilization review agent or URA--Has the meaning assigned by Insurance Code Chapter 4201 [~~Article 21.58A §2~~].

(b) When used in [~~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) impairment rating;

(12) [~~(11)~~] injury;

(13) [~~(12)~~] insurance carrier;

(14) maximum medical improvement; and

(15) [~~(13)~~] treating doctor.

§10.3. Contact Information.

Current email addresses, mailing addresses, and telephone numbers for the Division of Workers' Compensation and MCQA are available on the department's website. This contact information should be used when an email address, mailing address, or telephone number is referenced in a section in this chapter.

SUBCHAPTER B. CERTIFICATION
28 TAC §§10.20 - 10.27

STATUTORY AUTHORITY. The amendments to §§10.20 - 10.27 are proposed under Insurance Code §§1305.007, 1305.201, 4201.003, and 36.001.

Insurance Code §1305.007 provides that the Commissioner may adopt rules as necessary to implement Chapter 1305, concerning Workers' Compensation Health Care Networks.

Insurance Code §1305.201 provides for networks to prepare and file financial statements in the manner prescribed by Commissioner rule.

Insurance Code §4201.003 provides that the Commissioner may adopt rules as necessary to implement Chapter 4201, concerning Utilization Review Agents.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §10.20 implement Insurance Code §1305.051. The proposed amendments to §10.21 implement Insurance Code §1305.052. The proposed amendments to §10.22 implement Insurance Code §1305.053. The proposed amendments to §10.23 implement Insurance Code §1305.054. The proposed amendments to §10.24 implement Insurance Code §1305.053 and §1305.201. The proposed amendments to §10.25 implement Insurance Code §1305.102. The proposed amendments to §10.26 and §10.27 implement Insurance Code §1305.051 and §1305.052.

TEXT.

§10.20. Certification Required.

Except as provided by Labor Code §504.053(b)(2), concerning Election:

(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, concerning Workers' Compensation Health Care Networks, 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 MCQA mailing address [~~HMO Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 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, NAIC UCAA Form 11 (Rev. 12/8/2020), [~~adopted by reference under §7.507(b) of this title (relating 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 Chapter 1305, Subchapter D, concerning Contracting Provisions, [~~§§1305.151 - 1305.155~~] and §10.41 and §10.42 of this title [~~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, concerning Network-Carrier Contracts, and §10.41[~~(a)(1)~~] of this title (relating to Network-Carrier Contracts) [~~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 title [~~chapter~~];

(6) each management contract as described in §10.40 of this title [~~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, concerning Service of Process, for a domestic company;

(9) a description and a map of the applicant's proposed 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 Chapter 1305, Subchapter I, concerning Complaint Resolution, [~~§§1305.401 - 1305.405~~] and Chapter 10, Subchapter G, of this title [~~chapter~~] (relating to Complaints);

(B) a quality improvement program, including return-to-work and medical case management programs, as required under Insurance Code Chapter 1305, Subchapter G, concerning Provision of Services by Network; Quality Improvement Program, [~~§§1305.301 - 1305.304~~] and §10.81 of this title [~~chapter~~] (relating to Quality Improvement Program);

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

(D) the utilization review program [~~and retrospective review programs~~] described in Insurance Code Chapter 1305, Subchapter H, concerning Utilization Review, [~~§§1305.351 - 1305.355~~] and Chapter 10, Subchapter F, of this title [~~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 Chapter 1305, Subchapter G, [~~§§1305.301 - 1305.304~~] and §10.80 of this title [~~chapter~~] (relating to Accessibility and Availability Requirements). This description must [~~shall~~] include, at a minimum, the following:

(A) a map for each specialty providing services to injured employees in accordance with §10.80 of this title, each of which must include:

(i) each location of health care providers and facilities within the proposed service area, indicating each location by symbols of the network's own choosing; and

(ii) the distance from any point in the network's designated service area to each location;

(B) 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;

(C) [~~(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;

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

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

(F) information identifying which network providers provide telehealth service, telemedicine medical service, or teledentistry dental service, indicating which of these providers will provide telehealth service, telemedicine medical service, or teledentistry dental service only; and

(G) for any service area in which the network does not meet accessibility and availability requirements described in §10.80 of this title, an access plan that complies with §10.80(a) and (f) of this title;

(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)(E) [~~(D)~~] of this section have completed the training and testing required under Labor Code §408.023, concerning List of Approved Doctors; Duties of Treating Doctors, and rules adopted by the Commissioner of Workers' Compensation;

(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 [~~division of workers' compensation~~] under Labor Code §408.023 and §413.041, concerning Disclosure;

(18) the form of the notice of network requirements and employee information, and the acknowledgment form required under Insurance Code §1305.005, concerning Participation in Network; Notice of Network Requirements, and §10.60 of this title [~~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, concerning Guidelines and Protocols, and §10.83 of this title [~~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 title [~~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 will [~~commissioner shall~~] approve or disapprove an application for certification of a network in accordance with Insurance Code §1305.054, concerning Action on Application; Renewal of Certification.

§10.24. Network Financial Requirements.

(a) On at least a calendar year basis, each network must [~~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 must [~~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), concerning Network-Carrier Contracts; and §1305.155, concerning Compliance Requirements; and §10.41 of this title [~~chapter~~] (relating to Network-Carrier Contracts); and

(2) the department by sending the financial statement to the department's workers' compensation network email address [~~HMO Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104~~].

§10.25. Filing Requirements.

(a) A network must [~~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, concerning Management Contracts, and §10.40

of this title (relating to Management Contracts), 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 title [~~subchapter~~] (relating to Contents of Application); and

(3) material modification of network configuration in accordance with §10.27 of this title (relating to Modifications to Network Configuration). [~~; and~~]

(b) A network must file an [~~(4)~~] expansion, elimination, or reduction of an existing service area, or addition of a new service area with the department for approval before implementation and in accordance with §10.26 of this title (relating to Modifications to Service Area).

(c) [~~(b)~~] A network must [~~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 title [~~subchapter~~]. The information must be filed no later than 30 days after implementation of any change.

(d) Notwithstanding subsections (a) and (b) of this section, a network must notify the department of the sale of the network, the merger of the network with another entity, or any other organizational change at least 30 days before implementing the sale, merger, or organizational 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 title [~~subchapter~~] (relating to Contents of Application);

(2) network configuration information, as required under §10.22(11) of this title [~~subchapter~~]; and

(3) separate and consolidated projections as described in §10.22(13) of this title [~~subchapter~~] 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 title [~~subchapter~~];

(2) a brief narrative description of the administrative arrangements, organizational charts as required under §10.22(1) of this title [~~subchapter~~], 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 title [~~subchapter~~]; and

(4) a copy of each management contract as described under §10.22(6) of this title [~~subchapter~~].

(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, concerning Workers' Compensation Health Care Networks, and Labor Code Title 5, concerning Workers' Compensation, in the existing service areas and in each proposed service area.

(f) A corrected notice of network requirements and employee information form and acknowledgment form that comply with Insurance Code §1305.005, concerning Participation in Network; Notice of Network Requirements, and §1305.451, concerning Employee Information; Responsibilities of Employee, and §10.60 of this title (relating to Notice of Network Requirements; Employee Information) 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 department's workers' compensation network email address; or [~~HMO Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.~~]

(3) the MCQA mailing address.

§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 title [~~subchapter~~] (relating to Contents of Application); [~~and~~]

(2) network configuration information, as required by §10.22(11) of this title [~~subchapter.~~]; and

(3) if the modification involves adding or modifying telehealth service, telemedicine medical service, or teledentistry dental service, an explanation of how the network would update its provider directory, and any statements or restrictions on services that can be provided via telehealth service, telemedicine medical service, or teledentistry dental service.

(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 title [~~subchapter~~] 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, concerning Workers' Compensation Health Care Networks; and Labor Code Title 5, concerning Workers' Compensation.

(f) Prescribed modification request forms may be obtained from:

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

(2) the department's workers' compensation network email address; or [~~HMO Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.~~]

(3) the MCQA mailing address.

(g) For purposes of this section, a material modification includes a change to the network configuration that alters the ability of the network to comply with the availability and accessibility requirements described in §10.80 of this title (relating to Accessibility and Availability Requirements).

SUBCHAPTER C. CONTRACTING
28 TAC §§10.40 - 10.42

STATUTORY AUTHORITY. The amendments to §§10.40 - 10.42 are proposed under Insurance Code §§1305.007, 4201.003, and 36.001.

Insurance Code §1305.007 provides that the Commissioner may adopt rules as necessary to implement Chapter 1305, concerning Workers' Compensation Health Care Networks.

Insurance Code §4201.003 provides that the Commissioner may adopt rules as necessary to implement Chapter 4201, concerning Utilization Review Agents.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §10.40 implement Insurance Code §1305.102. The proposed amendments to §10.41 implement Insurance Code §1305.154. The proposed amendments to §10.42 implement Insurance Code §1305.152.

TEXT.

§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 [~~commissioner~~] in accordance with Insurance Code §1305.102, concerning Management Contracts.

(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.

(c) If a person is serving as both a management contractor or a third party to which the network delegates a function and as an agent of the health care provider, the contract between the management contractor or third party and the health care provider must comply with Insurance Code §1305.153, concerning Provider Reimbursement.

(d) A management contractor or a third party that is also serving as an agent for one or more health care providers in the certified network must meet the disclosure requirements with the certified network under Insurance Code §1305.153.

§10.41. Network-Carrier Contracts.

(a) With the exception of emergencies and out-of-network referrals, a network must provide health care services to employees only through a written contract with an insurance carrier.

(b) [~~(a)~~] A network's contract with a carrier must [~~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), concerning Network-Carrier Contracts, 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, concerning Workers' Compensation Health Care Networks; the Texas Workers' Compensation Act, Labor Code Title 5, Subtitle A, concerning Workers' Compensation; and the rules of the department and the Division [~~commissioner or the commissioner~~] of Workers' Compensation [~~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 and the network retain [~~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 or network'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 [~~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, claim 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 Chapter 4201, concerning Utilization Review Agents [~~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

(E) [~~(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 Chapter 4201 [~~Article 21.58A~~];

(12) an acknowledgment [~~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 title [~~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 [~~commissioner~~] to examine at any time any information the Commissioner [~~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 that has been delegated to the third party.

(15) a requirement that if the network delegates the complaint function, the delegate must:

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

(B) make the complaint log and complaint files available to the carrier and the network 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 must [~~shall~~] not be interpreted to involve a transfer of risk as defined under Insurance Code §1305.004(a)(26), concerning Definitions;

(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, concerning Compliance Requirements; [~~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, including Insurance Code §1305.152, concerning Network Contracts with Providers, and §10.42 of this title (relating to Network Contracts with Providers); and

(19) a statement that if a network's delegate subdelegates a network function, the delegate must first obtain the network's consent to the subdelegation and have a delegation agreement that complies with this section.

(c) [~~(b)~~] Except for the functions described under Insurance Code §1305.154(b) and §10.121 of this title [~~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.

(d) [~~(c)~~] A network must [~~shall~~] not act as a network for any entity regarding an insurance plan [~~which is~~] being operated in violation of Insurance Code §101.102, concerning Unauthorized Insurance Prohibited.

§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 must [~~shall~~] include, at a minimum, the following provisions:

(1) except as provided in Insurance Code §1305.451(b)(6), concerning Employee Information; Responsibilities of Employee, 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 title [~~chapter~~] (relating to Guidelines and Protocols) and the pharmacy closed formulary adopted by the Division of Workers' Compensation under §134.540 of this title (relating to Requirements for Use of the Closed Formulary for Claims Subject to Certified Networks), 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 must [~~shall~~] be resolved through the complaint resolution process under Insurance Code Chapter 1305, Subchapter I, concerning Complaint Resolution, [~~§§1305.401 - 1305.405~~] and Subchapter G of this title [~~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 must [~~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, concerning Posting of Information on Complaint Process Required. 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 must [~~shall~~] not be interpreted to involve a transfer of risk as defined under Insurance Code §1305.004(a)(26), concerning Definitions;

(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, concerning Payment of Health Care Provider,

and other applicable statutes and rules, including rules governing the billing and payment for certifications of maximum medical improvement and impairment rating examinations; [~~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; and

(15) a statement that the provider will receive written notice from the carrier if the carrier contests compensability of an injury the provider is treating as required under Insurance Code §1305.153(e), concerning Provider Reimbursement, including that the carrier may not deny payment for services provided prior to the issuance of the notice on the grounds that the injury was not compensable.

(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, concerning Guidelines and Protocols, and §10.83(a) of this title [~~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
28 TAC §§10.60 - 10.63

STATUTORY AUTHORITY. The amendments to §§10.60 - 10.63 are proposed under Insurance Code §§1305.007, 4201.003, and 36.001.

Insurance Code §1305.007 provides that the Commissioner may adopt rules as necessary to implement Chapter 1305, concerning Workers' Compensation Health Care Networks.

Insurance Code §4201.003 provides that the Commissioner may adopt rules as necessary to implement Chapter 4201, concerning Utilization Review Agents.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §10.60 implement Insurance Code §1305.451. The proposed amendments to §10.61 implement Insurance Code §1305.451. The proposed amendments to §10.62 implement Insurance Code §1305.451. The proposed amendments to §10.63 implement Insurance Code §1305.451.

TEXT.

§10.60. Notice of Network Requirements; Employee Information.

(a) An insurance carrier that establishes or contracts with a network must [~~shall~~] deliver to the employer, and the employer or carrier, as applicable under subsection (g) of this section, must [~~shall~~] deliver to the employer's employees in the manner and at the times prescribed by Insurance Code §1305.005, concerning Participation in Network; Notice of Network Requirements:

(1) the notice of network requirements and employee information required by Insurance Code §1305.005 and §1305.451, concerning Employee Information; Responsibilities of Employee, and this section; and

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

(b) Upon notification by the responsible party selected under subsection (g) of this section that health care services are being provided through the network, an [~~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:[~~,~~]

(1) may [~~shall~~] select a network treating doctor from the list of contracted doctors who contracted with the workers' compensation network; or

(2) request a doctor who the employee selected, prior to the injury, as the employee's HMO primary care physician or provider under Insurance Code Chapter 843, concerning Health Maintenance Organizations [~~,upon notification by the carrier that health care services are being provided through the network~~].

(c) The responsible party chosen under subsection (g) of this section must [~~carrier shall~~] provide to the employee all information required by Insurance Code §1305.451. The notice must include an employee acknowledgment [~~acknowledgement~~] form and comply with all requirements under subsections (d) [~~(c)~~] – (l) [~~(h)~~] of this section, as applicable.

(d) [~~(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 title [~~subchapter~~] (relating to Plain Language Requirements); and

(3) may be in an electronic format as long as [~~provided~~] a paper version is available upon request.

(e) [~~(d)~~] The responsible party chosen under subsection (g) of this section [~~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) HMO Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104~~].

(f) [~~(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.

(g) [~~(f)~~] The employer and carrier must determine whether the employer or the carrier will be responsible for obtaining a signed employee acknowledgment form from each employee and come to agreement on this. The employer and carrier must document the parties' agreement, which identifies the party who is responsible for obtaining a signed employee acknowledgment form from each employee. The employer and carrier must make the documentation available to the department and division upon request.

(h) The responsible party chosen under subsection (g) of this section must [~~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~~]. The responsible party [~~For purposes of this subsection, an employer or carrier, as applicable,~~] may obtain an acknowledgment [~~acknowledgement~~] of the notice required under this section through electronic means from an employee who makes an electronic signature in accordance with applicable law.

(i) [~~(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 title [~~subchapter~~] (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 title [~~subchapter~~] 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 must [~~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 email [~~e-mail~~] address of the contact; and

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

(i) an employee, employer, or person acting on behalf of the employee or employer if the employee, employer, or person acting on behalf of the employee or employer 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 title [~~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 must [~~shall~~] be identified and listed separately from specialists. Providers who are authorized to assess maximum medical improvement and render impairment ratings and providers who provide telehealth services, telemedicine medical services, or teledentistry dental services must [~~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.

(j) The responsible party chosen under subsection (g) of this section must [~~(h) An employer or carrier, as applicable, shall~~] deliver the notice of network requirements and acknowledgment form to the employer's employees, and document:

(1) the method of delivery;[,]

(2) to whom the notice was delivered;[,]

(3) the location of the delivery;[,] and

(4) the date or dates of delivery.

(k) The responsible party chosen under subsection (g) of this section must maintain copies of the notice of network requirements and employee information and the signed employee acknowledgment form for each employee. The copies may be maintained electronically, but the responsible party must be able to provide evidence that the notice was provided to and acknowledged by the employee.

(l) The failure of the responsible party chosen under subsection (g) of this section [~~an employer or carrier, as applicable,~~] to establish a standardized process for complying with subsection (j) of this section [~~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.

(m) A dispute regarding whether an employer or carrier provided the information required by this section to an employee may be resolved by requesting a benefit review conference as provided by Chapter 141 of this title (relating to Dispute Resolution--Benefit Review Conference).

§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, must [~~are required to~~] obtain medical treatment for a compensable injury from in-network providers [~~within the network~~], except as provided in Insurance Code §1305.006(1) and (3), concerning Insurance Carrier Liability for Out-of-Network Health Care; [~~and~~] subsection (e) [~~(f)~~](1), (3), and (4) of this section; and the rules of the Division of Workers' Compensation.

(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 title [~~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.

(e) [~~(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, concerning Workers' Compensation Health Care Networks, 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 must [~~shall~~] approve or deny a referral to an out-of-network [~~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, concerning Complaint Initiation and Initial Response; Deadlines for Response and Resolution, and §10.121 of this title [~~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 title [~~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, concerning Participation in Network; Notice of Network Requirements, and §10.60 of this title [~~subchapter~~] (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 must [~~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 must [~~shall~~] provide the employee with the notice of network requirements as described under §10.60 of this title [~~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 must [~~shall~~] notify the employee, in writing, of the carrier's determination. This notice must [~~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 must [~~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 title [~~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, concerning Employee Information; Responsibilities of Employee, and §10.60 of this title [~~subchapter~~] (relating to Notice of Network Requirements; Employee Information) must [~~shall~~] be written in plain language and comply with the following requirements:

(1) the text must [~~shall~~] achieve a minimum level of readability that [~~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 must [~~shall~~] be printed in not less than 12-point type;

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

(b) The notice of network requirements and employee information form described at §10.22(18) of this title [~~chapter~~] (relating to Contents of Application) must [~~shall~~] be filed with the department in accordance with §10.21 of this title [~~chapter~~] (relating to Certificate Application) and must [~~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 used [~~utilized~~] to determine the reading level, and that the form meets or exceeds the minimum readability standards established by the Commissioner [~~commissioner~~]. To confirm the accuracy of any certification, the Commissioner [~~commissioner~~] may require the submission of additional information.

SUBCHAPTER E. NETWORK OPERATIONS
28 TAC §§10.80 - 10.86

STATUTORY AUTHORITY. The amendments to §§10.80 - 10.86 are proposed under Insurance Code §§1305.007, 4201.003, and 36.001.

Insurance Code §1305.007 provides that the Commissioner may adopt rules as necessary to implement Chapter 1305, concerning Workers' Compensation Health Care Networks.

Insurance Code §4201.003 provides that the Commissioner may adopt rules as necessary to implement Chapter 4201, concerning Utilization Review Agents.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §10.80 implement Insurance Code §1305.301 and §1305.302. The proposed amendments to §10.81 implement Insurance Code §1305.303. The proposed amendments to §10.82 implement

Insurance Code §1305.303. The proposed amendments to §10.83 implement Insurance Code §1305.301. The proposed amendments to §10.84 implement Insurance Code §1305.103. The proposed amendments to §10.85 implement Insurance Code §1305.104. The proposed amendment to §10.86 implements Insurance Code §1305.107.

TEXT.

§10.80. Accessibility and Availability Requirements.

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

(b) The network must [~~shall~~] ensure that the network's provider panel includes:

(1) an adequate number of contracted 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 must [~~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, concerning List of Approved Doctors; Duties of Treating Doctors.

(c) Except for emergencies, a network must [~~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 must [~~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 must [~~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 [~~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) documentation that demonstrates how the network determined that providers are not located within the required distances; [~~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 in the access plan, 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; and

(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 and provider contracting plan through which health care services or providers will be made available and accessible to employees in these geographic areas in the future;

(5) if a general hospital is not available in an approved nonrural county, or a general acute hospital is available in an approved nonrural area but refuses to contract with the network, lists of:

(A) contracted providers who have admitting privileges in a general hospital in each approved nonrural area who may admit injured employees; and

(B) alternative but contracted nonacute care facilities that can provide required acute hospital services to injured employees;

(6) a list of the physicians, providers, and facilities within the relevant service area that the network attempted to contract with, identified by name and specialty or facility type, with:

(A) a description of how and when the network last contacted each physician, provider, or facility; and

(B) a description of the reason each physician, provider, or facility gave for declining to contract with the network; and

(7) any other information [~~which is~~] necessary to allow the department to assess and approve 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 must [~~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 must [~~shall~~] include return-to-work and medical case management programs. The network must [~~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 must [~~shall~~] develop a written description of the quality improvement program that outlines the program's [~~program~~] organizational structure, functional responsibilities, and committee meeting frequency;

(2) Work plan. The network must [~~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 must [~~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 [~~complaint and appeal~~] process, complaint data, and identification and removal of communication barriers that [~~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 must [~~shall~~] prepare an annual written report on the quality improvement program that [~~, 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; and

(5) the network has and will maintain documentation demonstrating that doctors who provide certifications of maximum medical improvement or assign impairment ratings to injured employees are authorized under §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment).

(d) The network governing body is ultimately responsible for the quality improvement program and must [~~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 must [~~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 must [~~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 must [~~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), concerning Return-to-Work Coordination Services, a claims adjuster may not serve as a case manager. The case manager must [~~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) Networks must have a documented process for selection and retention of preferred providers sufficient to ensure that preferred providers are adequately credentialed. At a minimum, a network's credentialing standards must meet the standards promulgated by the National Committee for Quality Assurance (NCQA) or URAC to the extent that those standards do not conflict with other laws of this state. Networks will be presumed to be in compliance with statutory and regulatory requirements regarding credentialing if they have received nonconditional accreditation or certification by the NCQA, the Joint Commission, URAC, or the Accreditation Association for Ambulatory Health Care; maintain evidence of that accreditation or certification; and provide it to the department on request.

(b) The requirements of §10.41 of this title (relating to Network-Carrier Contracts) apply to delegation of 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;~~]

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

[~~(III) students, residents, or fellows;~~]

[~~(IV) pharmacists; or~~]

[~~(V) opticians.~~]

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

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

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

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

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

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

[~~(III) complaints; and~~]

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

[~~(viii) The network's procedures shall ensure that selection and retention criteria do not discriminate against doctors or health care practitioners who serve high-risk populations. Procedures shall also include a provision that credentialing and recredentialing decisions are not based on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures performed or types of patients.~~]

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

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

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

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

~~health care practitioners. The completion date on the application shall be within 180 calendar days prior to the date the credentialing committee deems a doctor or health care practitioner eligible for initial credentialing.~~]

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

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

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

[~~(III) Board certification, if the doctor or health care practitioner indicates that he/she is board certified on the application. The network may obtain primary source verification from the American Board of Medical Specialties Compendium, the American Osteopathic Association, the American Medical Association MasterFile, or from the specialty boards, and the network must use the most recent available source.~~]

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

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

[~~(-b-) visual inspection of the original certificate;~~]

[~~(-c-) confirmation with DEA or DPS;~~]

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

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

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

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

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

[~~(-a-) National Practitioner Data Bank;~~]

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

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

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

[~~(-e-) Federation of State Medical Boards;~~]

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

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

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

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

[~~(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;~~]

[~~(II) 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.~~]

(c) [~~(d)~~] Delegation of credentialing.

(1) If the network delegates credentialing functions to other entities, it must [~~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 title [~~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 must [~~shall~~] be made available to the department for review.

(3) The network must [~~shall~~] maintain and must [~~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 must [~~shall~~] be made available to the department for examination upon request.

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

(d) Compliance. Until September 23, 2022, entities subject to this section will be deemed to be in compliance with the section if they are in compliance with the section as adopted to be effective December 5, 2005. Entities subject to this section must make a filing attesting to compliance no later than September 23, 2022.

§10.83. Guidelines and Protocols.

(a) Each network must [~~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 must [~~shall~~], through its quality improvement program under §10.81 of this title [~~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 must [~~shall~~] contractually require providers to follow treatment guidelines, return-to-work guidelines, and individual

treatment protocols pursuant to §10.42(b)(2) of this title [~~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, concerning Workers' Compensation Health Care Networks, and this chapter, a doctor designated as a treating doctor by a network must [~~shall~~] comply with Labor Code §§408.0041(c) and (g), concerning Designated Doctor Examination; 408.025(c), concerning Reports and Records Required from Health Care Providers; [~~and~~] 408.023(l) - (p), concerning List of Approved Doctors; Duties of Treating Doctors; and rules adopted by the Commissioner [~~commissioner~~] of Workers' Compensation [~~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), concerning Selection of Treating Doctor.

(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 must [~~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 - I, and [~~commissioner~~] rules adopted under those subchapters, as applicable to treating doctors.

§10.86. Telephone Access.

Each network must [~~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
28 TAC §§10.100, 10.101, and 10.104

STATUTORY AUTHORITY. The amendments to §§10.100, 10.101, and 10.104 are proposed under Insurance Code §§1305.007, 4201.003, and 36.001.

Insurance Code §1305.007 provides that the Commissioner may adopt rules as necessary to implement Chapter 1305, concerning Workers' Compensation Health Care Networks.

Insurance Code §4201.003 provides that the Commissioner may adopt rules as necessary to implement Chapter 4201, concerning Utilization Review Agents.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §10.100 implement Insurance Code §1305.351. The proposed amendments to §10.101 implement Insurance Code §1305.353 and §1305.354. The proposed amendments to §10.104 implement Insurance Code §1305.355 and §1305.356.

TEXT.

§10.100. Applicability.

In addition to the requirements under this subchapter, the requirements of Insurance Code Chapter 4201, concerning Utilization Review Agents, [~~Article 21.58A~~] apply to utilization review conducted in relation to a workers' compensation health care network. In the event Chapter 4201 [~~Article 21.58A~~] conflicts with this chapter and Insurance Code Chapter 1305, concerning Workers' Compensation Health Care Networks, 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.

(c) Under Insurance Code §4201.152, concerning Utilization Review Under Physician, a network that uses doctors to perform reviews of health care services provided under this chapter, including utilization review, or peer reviews under Labor Code §408.0231(a), concerning Maintenance of List of Approved Doctors; Sanctions and Privileges Relating to Health Care, may only use doctors licensed to practice in this state.

(d) Physicians and doctors conducting utilization review must hold a professional certification in a health care specialty appropriate to the type of health care the injured employee is receiving as required by Labor Code §§408.0043 - 408.0045, concerning Professional Specialty Certification Required for Certain Review, Review of Dental Services, and Review of Chiropractic Services. Physicians, doctors, and other health care providers conducting utilization review must have the appropriate credentials as required by Chapter 180 of this title (relating to Monitoring and Enforcement).

(e) The preauthorization requirements of Labor Code §413.014, concerning Preauthorization Requirements; Concurrent Review and Certification of Health Care, 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 Chapter 1305, Subchapter H, concerning Utilization Review, and this chapter apply.

(f) Insurance Code Chapter 1305, Subchapter H, and applicable network requirements in Chapter 19, Subchapter U, of this title (relating to Utilization Reviews for Health Care Provided Under Workers' Compensation Insurance Coverage), apply to

utilization review for health care provided through a workers' compensation network that is conducted by insurance carriers, utilization review agents, and networks that perform utilization review for or on behalf of insurance carriers and utilization review agents.

(g) In addition to the requirements in subsection (f) of this section, the reconsideration procedures must include a method for expedited reconsideration procedures in accordance with Insurance Code §1305.354(b) and (c), concerning Reconsideration of Adverse Determination.

§10.104. Independent Review of Adverse Determination.

(a) Requirements for independent review of an adverse determination are governed by Insurance Code Chapter 1305, concerning Workers' Compensation Health Care Networks, and department and Division of Workers' Compensation rules, including Chapter 10, Subchapter F, of this title (relating to Utilization Review), Chapter 12 of this title (relating to Independent Review Organizations), Chapter 19 of this title (relating to Licensing and Regulation of Insurance Professionals), and §133.308 of this title (relating to MDR of Medical Necessity Disputes).

(b) 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 (c) [~~(b)~~] of this section by an independent review organization assigned in accordance with Insurance Code Chapter 4202, concerning Independent Review Organizations, and department and Division of Workers' Compensation rules [~~Article 21.58C and commissioner rules~~]; and

(2) provide to the appropriate independent review organization the information and documents listed in §133.308(k) of this title (relating to MDR of Medical Necessity Disputes) and the response letter described by Insurance Code §1305.354(a)(4), concerning Reconsideration of Adverse Determination, 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 subchapter (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~~].

(c) [~~(b)~~] A requestor must timely file a request for independent review under subsection (b) [~~(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.

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

(e) [~~(d)~~] The department will [~~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.~~]

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

(g) A party to a medical dispute that remains unresolved after a review under this section is entitled to a contested case hearing. A hearing under this section will be conducted by the Division of Workers' Compensation in the same manner as a hearing conducted under Labor Code §413.0311, concerning Review of Medical Necessity Disputes; Contested Case Hearing, and Division of Workers' Compensation rules.

(h) The department and the Division of Workers' Compensation are not considered to be parties to the medical dispute.

(i) [~~(h)~~] If [~~judicial~~] review is not sought under subsection (g) of this section, the carrier and network must [~~shall~~] comply with the independent review organization's decision.

SUBCHAPTER F. UTILIZATION REVIEW AND RETROSPECTIVE REVIEW
28 TAC §10.102 and §10.103

STATUTORY AUTHORITY. The repeals of §10.102 and §10.103 are proposed under Insurance Code §§1305.007, 4201.003, and 36.001.

Insurance Code §1305.007 provides that the Commissioner may adopt rules as necessary to implement Chapter 1305, concerning Workers' Compensation Health Care Networks.

Insurance Code §4201.003 provides that the Commissioner may adopt rules as necessary to implement Chapter 4201, concerning Utilization Review Agents.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

CROSS-REFERENCE TO STATUTE. The proposed repeals of §10.102 and §10.103 implement Insurance Code Chapter 4201.

TEXT.

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

§10.103. Reconsideration of Adverse Determination.

SUBCHAPTER G. COMPLAINTS
28 TAC §§10.120 - 10.122

STATUTORY AUTHORITY. The amendments to §§10.120 - 10.122 are proposed under Insurance Code §§1305.007, 4201.003, and 36.001.

Insurance Code §1305.007 provides that the Commissioner may adopt rules as necessary to implement Chapter 1305, concerning Workers' Compensation Health Care Networks.

Insurance Code §4201.003 provides that the Commissioner may adopt rules as necessary to implement Chapter 4201, concerning Utilization Review Agents.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §10.120 implement Insurance Code §1305.401. The proposed amendments to §10.121 implement Insurance Code §1305.402. The proposed amendments to §10.122 implement Insurance Code §§1305.403, 1305.551, and 1305.552.

TEXT.

§10.120. Complaint System Required.

(a) Each network must [~~shall~~] implement and maintain a complaint system compliant with Insurance Code Chapter 1305, Subchapter I, concerning Complaint Resolution, [~~§§1305.401 - 1305.405~~] and this subchapter that provides reasonable procedures for resolving an oral or written complaint.

(b) For purposes of this subchapter, a complaint relating to a fee dispute is a complaint from a provider regarding the network's failure to pay a claim in accordance with the contract between the network and provider.

§10.121. Complaints; Deadlines for Response and Resolution.

(a) Not later than seven calendar days after receipt of an oral or written complaint, a [~~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 must [~~shall~~] investigate each oral or written 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 must [~~shall~~] issue a resolution letter to the complainant not later than the 30th calendar day after the network receives the written complaint that [~~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) explains the network's procedures and deadlines for filing an appeal of the complaint; and

(5) [~~(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 title [~~subchapter~~] (relating to Submitting Complaints to the Department).

(d) A network must [~~shall~~] maintain a complaint-and-appeal [~~complaint~~] log regarding each complaint and categorize each complaint and appeal 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-and-appeal [~~complaint~~] log required under subsection (d) of this section and documentation on each complaint, complaint appeal, 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) HMO Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104~~].

SUBCHAPTER H. EXAMINATIONS
28 TAC §10.200

STATUTORY AUTHORITY. The amendments to §10.200 are proposed under Insurance Code §§1305.007, 1305.251, and 36.001.

Insurance Code §1305.007 provides that the Commissioner may adopt rules as necessary to implement Chapter 1305, concerning Workers' Compensation Health Care Networks.

Insurance Code §1305.251 provides for the Commissioner to set and collect fees for network examinations under §1305.251 or §1305.252.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §10.200 implement Insurance Code §1305.251.

TEXT.

§10.200. Fee for Examination of a Certified Workers' Compensation Health Care Network.

(a) As provided in Insurance Code §1305.251, concerning Examination of Network, a network must [~~shall~~] pay to the department an examination fee set by the Commissioner for expenses directly attributable to an examination of the network conducted pursuant to Insurance Code §1305.251 or §1305.252, concerning Examination of Provider or Third Party.

(b) The examination fee includes [~~shall include~~] the actual salary and expenses of the examiners directly attributable to the examination.

(1) The actual salary of an examiner is determined by dividing the annual salary of the examiner by the total number of working days in a year, then dividing that amount by the number of hours in a working day. The actual salary included in an examination fee is [~~shall be~~] the part of the annual salary attributable to each hour the examiner examines the network.

(2) The expenses included in an examination fee are [~~shall be~~] those actually incurred by the examiner and directly attributable to the examination, including the actual cost of:

(A) transportation;[~~,~~]

(B) lodging;[~~,~~]

(C) meals;[,]

(D) subsistence expenses;[,]

(E) parking fees;[,] and

(F) department overhead expenses [~~expense~~].

(c) An examination fee paid pursuant to this section is [~~shall be~~] payable and due to the Texas Department of Insurance at the address given on the invoice [~~, P.O. Box 149104, Mail Code 108-3A, Austin, Texas 78714-9104,~~] no later than 30 days from the invoice date.

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

Issued in Austin, Texas, on January 14, 2022.

DocuSigned by:
James Person
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James Person, General Counsel
Texas Department of Insurance