CHAPTER 10. WORKERS' COMPENSATION HEALTH CARE NETWORKS

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

SUBCHAPTER B. CERTIFICATION
28 TAC §§10.20 - 10.27

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SUBCHAPTER F. UTILIZATION REVIEW
28 TAC §§10.100, 10.101, and 10.104

SUBCHAPTER G. COMPLAINTS
28 TAC §§10.120 - 10.122

SUBCHAPTER H. EXAMINATIONS
28 TAC §10.200

INTRODUCTION. The Commissioner of Insurance adopts the repeal of 28 TAC §10.102 and §10.103; new §10.3; and amendments to §§10.1, 10.2, 10.20 - 10.27, 10.40 - 10.42, 10.60 - 10.63, 10.80 - 10.86, 10.100, 10.101, 10.104, 10.120 - 10.122, and 10.200, concerning workers' compensation health care networks.

The Commissioner adopts the repeal of §10.102 and §10.103, new §10.3, and amended §§10.1, 10.21, 10.23, 10.24, 10.25, 10.27, 10.40, 10.42, 10.62, 10.63, 10.80, 10.84,

10.85, 10.86, 10.100, 10.101, 10.104, 10.122, and 10.200 without changes to the proposed text published in the February 4, 2022, issue of the *Texas Register* (47 TexReg 457).

The Commissioner adopts amendments to the following sections with changes to the proposed text published in the February 4, 2022, issue of the *Texas Register*: §§10.2, 10.20, 10.22, 10.26, 10.41, 10.60, 10.61, 10.81, 10.82, 10.83, 10.120, and 10.121. Changes to the proposed rule text include changes made in response to comment, and additional minor changes to wording and punctuation for clarification, consistency within rule text, and consistency with department language preferences and drafting practices.

In the April 1, 2022, issue of the *Texas Register* (47 TexReg 1740), the Secretary of State's Office corrected an error it made to the proposed amendments to 28 TAC §10.60(j)(4). The text for proposed paragraph (4) of subsection (j) was incorrectly identified as new language. Only the paragraph number should have been listed as new language. In the same issue, the department posted a Notice of Hearing for the proposal.

REASONED JUSTIFICATION. The repeals, new section, and amendments in Chapter 10 are necessary to implement legislative amendments to the Insurance Code. Some of the amendments implement changes to Insurance Code Chapter 1305, as added by House Bill 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 1107, 85th Legislature, 2019, and HB 2056, 87th Legislature, 2021. This adoption 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, which was recodified and amended after the Chapter 10 rules were adopted. Recent updates to the Utilization Review Agent rules in 28 TAC Chapter 19 also generally apply to certified networks, so conforming edits are made to Chapter 10 to decrease rule redundancy. The 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 department language preferences and drafting practices.

The new and amended sections are described in the following paragraphs, organized by subchapter.

Subchapter A. General Provisions and Definitions.

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

Section 10.2. The amendments to §10.2 update and add more complete statutory citations, clarify existing and add new definitions, and make changes to conform to current department language preferences and drafting practices. Specifically, the 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, and to provide consistency with the

requirements in Labor Code §408.021(a) and §413.014(c)(6) and the definition in 28 TAC §19.2003(b)(1) and §134.600(a)(1);

- add the defined terms "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 defined term "nurse" because the term is no longer used in 28 TAC Chapter 10;

- amend the definition of "preauthorization" 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; and

- update the list of terms that have the meanings assigned by Labor Code §401.011 to include "impairment rating" and "maximum medical improvement."

The department revised proposed §10.2(a)(9) to clarify that the "Division of Workers' Compensation" has the meaning assigned to the "Division" by Labor Code §401.011.

In response to a comment, the department revised proposed §10.2(a)(33) to clarify that "service area" has the meaning assigned by Insurance Code §1305.004(a)(24).

Section 10.3. 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 the department'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 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. The department revised the text of §10.20 as proposed to replace a comma with a semicolon after the word "chapter" in §10.20(1)(A).

Section 10.21. The 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 information change.

Section 10.22. The amendments to §10.22 add more complete statutory citations and make changes to conform to current department language preferences and drafting practices. In addition, the 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, to simplify applications and shorten processing times by eliminating delays when the department requests these materials;

- require information about providers that provide telehealth service, telemedicine medical service, or teledentistry dental service so the department can know 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 the department 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.

The department revised the proposed text of §10.22(20) to add the words "and be designed to reduce inappropriate or unnecessary health care while safeguarding necessary care" as stated in Insurance Code §1305.304 and 28 TAC §10.83(a).

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

Section 10.24. The 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 department language preferences and drafting practices.

Section 10.25. The amendments to §10.25 add more complete statutory citations and make changes to conform to current department language preferences and drafting practices. The 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 the department for approval before implementation and in accordance with the prior approval requirement in §10.26; and

- add a requirement that a certified network notify the department 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 amendments to §10.26 add more complete statutory citations and make changes to conform to current department language preferences and drafting practices. In addition, the 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.

The department made a change from the proposal to replace a comma with a semicolon after the word "Requirements" in the text added to §10.26(f).

The department made a change from the proposal to replace a comma with a semicolon after the words "chapter" and "Networks."

Section 10.27. The amendments to §10.27 add more complete statutory citations and make changes to conform to current department language preferences and drafting practices. Also, the 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 amendments to §10.40 add more complete statutory citations and make a change to conform to current department 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 amendments to §10.41 add more complete statutory citations and make changes to conform to current department language preferences and drafting practices. The amendments also:

- 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 the department will know how many claims are 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.

In response to a comment that the language in proposed §10.41(a) did not include statutory language about confidentiality, the department declined to adopt proposed §10.41(a) because it is not necessary to repeat statutory language. The department redesignated proposed §10.41(b) - (d) as §10.41(a) - (c).

Section 10.42. The amendments to §10.42 add more complete statutory citations and make changes to conform to current department language preferences and drafting practices. The 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 the department 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 the department 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 §1305.153(e); and

- the carrier may not deny payment for services provided before the issuance of the notice on the grounds that the injury was not compensable, to conform to Insurance Code §1305.153(e).

Subchapter D. Network Requirements.

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

- 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 before 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;"

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

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

- clarify that the failure of an employer or carrier, as applicable, 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; and

- provide that a dispute regarding whether an employer or carrier properly provided the information required by §10.60 to an employee may be resolved by requesting a benefit review conference as provided under Insurance Code §1305.103(c) and §1305.451(e).

The department revised the proposed amendments to §10.60(b) by placing the word "may" at the end of §10.60(b), rather than the beginning of §10.60(b)(1). The department also revised the proposed text by adding a comma after the word "section" in proposed §10.60(e). In addition, the department changed proposed §10.60(f)(2)(A)(i) by replacing a comma with a semicolon after the word "network," and the department made a change from the proposal to add a comma after the word "name" in §10.60(f)(3).

In response to comments, the department declined to adopt proposed new §10.60(g), which would have provided for an employer and carrier to determine which party would be responsible for obtaining a signed acknowledgment form. As part of this change from the proposed text, the department declined to establish a new §10.60(h), and it retained text that would have been deleted as part of the proposed change. For consistency with these changes, the department redesignated the subsections that follow §10.60(g) to reflect that new §10.60(g) is not adopted, and the department made additional changes to the proposal to delete references to "responsible party" in §10.60(b), (c), (e), (i), (j), and (k), as adopted.

The department made changes to §10.60(g) as adopted to add "concerning Treating Doctor; Referrals" following the citation to Insurance Code §1305.103(c) and to replace the word "shall" with "must" to conform to current department language preferences and drafting practices. The department revised proposed §10.60(h)(14)(A) to change "telehealth services, telemedicine medical services, or teledentistry dental

services" to "a telehealth service, telemedicine medical service, or teledentistry dental service" for consistency in terminology within the rule text.

In response to a comment, the department declined to adopt proposed §10.60(k). The subsections that followed proposed §10.60(k) have been redesignated as appropriate to reflect this change from the proposed text.

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

In response to a comment that deleting §10.61(d) would remove the ability of an employee and network to agree that the employee may participate in a network even though the employee does not live within the network service area, the department retained §10.61(d). For consistency with this change, the department redesignated proposed §10.61(e) and (f) as §10.61(f) and (g) in the adopted text.

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

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

Subchapter E. Network Operations.

Section 10.80. The amendments to §10.80 make changes to conform to current department language preferences and drafting practices. The 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 the department;

- remove duplicative requirements in current §10.80(g)(4)(B) and (C), which are already included in §10.80(f) and new subsection (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 amendments to §10.81 add more complete statutory citations and make changes to conform to current department language preferences and drafting practices. In addition, the 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.

The department made a change to §10.81(c)(1) as proposed to change "the Joint Commission on Accreditation of Healthcare Organizations" to "The Joint Commission."

Section 10.82. The amendments to §10.82 make changes to conform to current department language preferences and drafting practices. The 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 amendments by permitting entities subject to §10.82 to comply with the section as it currently exists until January 1, 2023; entities will have until January 1, 2023, to make a filing attesting to compliance with the rule amendments.

The department revised §10.82(a) as proposed to capitalize the word "the" before "Joint Commission."

In response to comments to change the September 23, 2022, compliance date in proposed §10.82(d) for credentialing standards, the department changed the date to January 1, 2023.

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

The department revised §10.83(a) as proposed to add "be" before "designed," for consistency with Insurance Code §1305.304 and 28 TAC §10.22(20).

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

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

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

Subchapter F. Utilization Review.

The amendments delete "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 amendments to §10.100 correct obsolete citations and add more complete statutory citations.

Section 10.101. The amendments to §10.101 make changes to conform to current department language preferences and drafting practices. The 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 repealed. The general standards for utilization review addressed in those sections are replaced with new subsections in §10.101.

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

- insert references to Insurance Code Chapter 1305, Subchapter H, and department and Division of Workers' Compensation rules to clarify applicable requirements for 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 the department and the Division of Workers' Compensation are not considered to be parties to a medical dispute.

Subchapter G. Complaints.

Section 10.120. The amendments to §10.120 make changes to the section to conform to current department 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 failure to pay a claim in accordance with the contract between the certified network and provider.

In response to a comment to change the language concerning "a network's failure to pay," the department deleted "the network" in proposed §10.120(b) because a health care network is not always the payor.

Section 10.121. The amendments to §10.121 make changes to conform to current department language preferences and drafting practices. The 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.

The department changed proposed §10.121(e) in response to a comment for clarification on the meaning of the term "complaint appeal" by removing the term. The language now states that each network must maintain the required complaint-and-appeal log and documentation on each complaint, appeal, complaint proceeding, and action taken on the complaint until the third anniversary after the date the complaint was received.

Section 10.122. The 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 the department's website.

Subchapter H. Examinations.

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

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: The department received written comments from 27 commenters, and two of the commenters also spoke at a public hearing on the proposal held on April 13, 2022. Commenters in support of the proposal with changes were American Property Casualty Insurance Association, Coventry, Jackson Star Consulting LLC, North Texas Pain Recovery Center, Office of Injured Employee Counsel, Stone Loughlin Swanson, and 20 individuals.

Comments on proposed rules generally

Comments. Two commenters expressed general support for the proposed workers' compensation health care network rules. One commenter supports updating the rules to add complete statutory citations and simplifying and updating rule language. Another commenter states that the amendments help reduce existing burdens on networks and carriers for supplying unnecessary data requirements, make the credentialing process more efficient and consistent with national standards, make the rules more consistent with statutory amendments, and update the rules by deleting obsolete references to statute.

Agency Response. The department appreciates the support.

Comment on §10.2

Comment. A commenter addresses the definitions for "preauthorization" and "service area" in §10.2, saying that they appear to have been updated in the proposed rule but do not align with definitions for the same terms contained in Insurance Code §1305.004(a)(19) and (24), respectively. The commenter requests aligning the definitions.

Agency Response. The department agrees to change the definition for "service area" in proposed §10.2(a)(33) for consistency with Insurance Code §1305.004(a)(24) by stating that "service area" has the meaning assigned by Insurance Code §1305.004. The department declines to change the "preauthorization" definition, which conforms with the definition of "utilization review" under Insurance Code §4201.002(13) to include prospective, concurrent, and retrospective review. This definition is also consistent with Labor Code §413.014 and 28 TAC §134.600(a)(7).

Comment on §10.22

Comment. A commenter says that the requirement to include information about providers of telehealth service, telemedicine medical service, or teledentistry dental service in each certification application benefits the Texas workers' compensation system. The commenter states that as the use of these types of services increases, tracking these providers ensures compliance with the Labor Code and Division of Workers' Compensation rules and that these changes will simplify the application process and shorten processing times. The commenter says that requiring applicants to verify that the certified network doctors have completed training and testing required by the Labor Code and Division rules ensures that qualified doctors are available to help injured employees of Texas.

Agency Response. The department appreciates the support.

Comment on §10.22(10)(C)

Comment. One commenter requests not requiring networks to provide credentialing information. The commenter explains that this is a manual process to complete and is administratively burdensome. The commenter states that with the revised credentialing requirements, a networks' NCQA/JCAHO/URAC accreditations could be considered by the state to be sufficient to demonstrate that providers within the network are appropriately credentialed, without a redundant separate listing of credentialing detail.

Agency Response. The department does not agree that the process to submit credentialing information is overly burdensome and declines to waive or otherwise modify the submission requirement. The department notes that credentialing information is only required to be submitted upon request, and the department has the option to verify the

network's credentialing process upon request. The request would be in conjunction with a desk audit, complaint review, or an examination. This does not require an annual report and TDI does not expect it to be too burdensome for networks that are in compliance with the national accrediting standards.

Comment on §10.22(11)(A)

Comment. A commenter describes concerns about the requirement that a certificate application include maps that demonstrate compliance with the access and availability standards under Insurance Code Chapter 1305. The commenter says that providing a map for each and every specialty would be costly and overly burdensome and that creating maps for each specialty, including specialties that are not commonly involved in the treatment of workplace injuries, far outweighs the benefit such maps could provide. The commenter suggests that only specialties commonly related to the treatment of workplace accidents should be included in the maps. The commenter states that many networks include some providers in specialty areas that are not commonly needed to treat workplace industries, such as pediatric care, obstetrics and gynecology, urology, and nuclear medicine. The commenter notes that the current regulations discuss "the adequacy of the network configuration to provide comprehensive health care services sufficient to serve the population of injured employees within the service area" and suggests that the maps in the proposed rule should likewise be limited to only those specialties adequate to serve the population of injured workers.

Agency Response. Although the number of maps for certain specialties can change, the department currently requests that workers' compensation networks submit maps for 21 specialties as opposed to group health plans, which submit maps for 42 specialties. Given

the difference, the department does not anticipate that providing these maps will be overly burdensome. The changes made to the requirements for network adequacy reviews were done to standardize network review for all networks, including group health and certified workers' compensation health care networks. Furthermore, the department believes that network maps should contain providers who can provide the most commonly needed services for injured employees. Therefore, the department declines to further limit the specialties for which maps are required under this rule.

Comment on §10.22(11)(B) - (F)

Comment. A commenter requests confirmation that, when sharing provider data under proposed §10.22(11)(B) - (F), the required data elements include only the following (by provider category):

- Individual Providers: Name, Address, Specialty, Board Certifications, License Numbers, Hospital Affiliations, Accepting New Patients, and MMI/IR Certificates

- Telemedicine Offering Facilities: Name, Address, FEIN, License, Facility Type, Accepting New Patients, and Telemedicine Offering

The commenter also states that some recently submitted filings require additional data elements, such as credentialing dates and status, initial versus re-credentialing, hospital-based provider status, and telephone number.

The commenter also states that facility FEIN is not included in the state's current file layout but is referenced in the rule. The commenter requests clarification in the rules to streamline the process and to make certain the state receives the information in a timely and efficient manner.

Agency Response. The department declines to modify the rules in response to this comment, but notes that only elements included in statute and rule are required to be submitted, and no amendments were proposed to the existing data elements in §10.22(11)(B) – (E).

Comment on §10.22(11)(F)

Comment. A commenter discusses telehealth, noting that is an emerging field and medical providers, networks, carriers, and the public are currently, and on an ongoing basis, gauging the appropriate extent of the scope of telehealth and telemedicine. The commenter says that new developments in telehealth as an effective and appropriate way to provide medical services have been highlighted recently during the pandemic. The commenter states that, due to the fluid nature of the emerging practice of telemedicine, and providers adopting telemedicine processes on either a temporary or permanent basis, and perhaps, at times, disengaging from telemedicine, it is not possible to state categorically whether a provider may be offering telemedicine services at a particular time. Based on this, the commenter recommends that proposed §10.22(11)(F) not be included in the adopted rule.

Agency Response. The department disagrees with removing proposed §10.22(11)(F). Because telehealth, telemedicine medical, and teledentistry dental services are part of an emerging field that is being utilized by patients more often, injured employees should be able to use the directory to find providers that provide those services.

Comment on §10.24(b)(1)

Comment. In regard to §10.24(b)(1), a commenter says that carriers do not want to receive the network's financial information and that carriers do not review them. The commenter says the annual filing includes confidential financial information, so changes should be made to allow for provision of these documents only upon request. The commenter proposes alternative text to effectuate this recommendation.

Agency Response. The department disagrees with the suggested changes because the commenter's concerns are outside the scope of the proposed rules. The financial statement submission requirements exist in the current rule, and the department only proposed nonsubstantive changes to §10.24(b)(1).

Comment on §10.25(a)(2)

Comment. A commenter recommends changing §10.25(a)(2) because most books and records are now housed electronically and not at a physical location. The commenter recommends that any updates to the "Physical Location of Books and Records" exhibit be filed as an information-only filing rather than 30 days before use and requiring the department’s approval.

Agency Response. The department disagrees with the suggested changes because the commenter's concerns are outside the scope of the proposed rules. The filing requirement at issue currently exists in §10.25(a)(2), and the department proposed only nonsubstantive changes to the rule.

Comments on §10.27(b)(3)

Comment. A commenter expresses concern with the language "and any statements or restrictions on services that can be provided via telehealth service, telemedicine medical

service, or teledentistry dental service" in §10.27(b)(3). The commenter states that it would be unduly complicated and burdensome for the department to require insurers to include "any statements or restrictions" on telehealth services in the directory because that could potentially be an extensive amount of information, which would be unrealistic to display in the directory and could be confusing to a claimant. The commenter says that because of the fluid nature of the emerging practice of telemedicine and because providers sometimes adopt telemedicine processes on either a temporary or permanent basis and at times disengaging from telemedicine, it is not possible to state categorically whether a provider may be offering telemedicine services at a particular time. The commenter recommends deleting the proposed provision.

Another commenter states that many health care networks previously submitted a summary of their telemedicine services to the department before the drafting of the proposed rules, in response to the overwhelming demand for telemedicine services seen during the pandemic. The commenter requests clarification in the rule that health care networks that have already submitted a summary of their telemedicine services to the department have already satisfied this requirement. The commenter also states that if the intention of the proposed rules is to require a duplicate material modification filing for telemedicine services, then the department should allow at least 90 days from the effective date of the rules for health care networks to gather necessary documentation to file the material modification.

Agency Response. Section 10.27(b)(3) applies to modifications made on or after January 1, 2023. The department disagrees with adding language to clarify that networks that have already submitted a summary of their telehealth service, telemedicine medical service, or teledentistry dental service to the department prior to the rule adoption will have already

satisfied this requirement. The department also disagrees with deleting §10.27(b)(3). Because telehealth, telemedicine medical, and teledentistry dental services are part of an emerging field, it is important that health care networks inform the department about adding or modifying those services. Also, injured employees should be able to use the directory to find providers that provide those services. Provider directories exist to provide prospective patients with information to choose a provider that will meet their needs. Including the telehealth and telemedicine information via a legend or key in the directory should not be overly burdensome for the workers' compensation health networks and will provide injured employees with adequate information to select the appropriate provider for their needs. Group health provider directories already provide this information in an effort to better serve their members.

Comment on proposed §10.41(a)

Comment. A commenter states that, while the proposed language is taken from Insurance Code §1305.154, the draft rule omits the statutory language that network-carrier contracts are to remain confidential and are not subject to disclosure as public information. It is critical that such contracts remain confidential, in accordance with the statute. The commenter recommends that the language of proposed §10.41(a) not be adopted or, if adopted, that text based on the statutory language regarding confidential information be added to the rule.

Agency Response. The department has not included the text of proposed §10.41(a) in the adoption because it is not necessary to repeat Insurance Code §1305.154(a) in rule.

Comment on proposed §10.41(b)(7) (which is adopted as §10.41(a)(7))

Comment. A commenter states that many carriers do not wish to receive the specified data that networks provide to comply with monthly reporting requirements under proposed §10.41(b)(7); they would instead prefer to receive it only when requested. The commenter states that the required data list includes confidential information, including protected health information for injured workers and a network's financial records. The commenter suggests limiting distribution to ensure that only those who need the data for a valid purpose have access. The commenter proposes alternative text to effectuate its recommendation.

The commenter states that removing the burden of providing reports that the carrier may not want to receive helps to improve administrative efficiency for both the network providers as well as payors.

Agency Response. The department disagrees with the suggested changes because the commenter's concerns are outside the scope of the proposed rules. The filing requirement at issue existed in the rule prior to proposal, and the department proposed only one substantive amendment: the new requirement to include the claim number in the filing. The commenter does not specifically object to the inclusion of claim numbers, but objects to the existing filing requirement in general. As such, the commenter's concerns are outside the scope of this rulemaking.

Comment on proposed §10.41(b)(19) (which is adopted as §10.41(a)(19))

Comment. A commenter says that with §10.41(a)(19) the rules add a beneficial requirement for a delegate of the health care network to notify the health care network if the delegate further subdelegates services. The commenter also notes that the rule would require that a health care network delegate have a formal delegation agreement in place

with the subdelegate. However, the commenter observes that the section does not specify whether the health care network is required to provide notification to the state of the subdelegation, and the commenter suggests that the section be modified to indicate whether state notification is required and, if it is required, provide that notification must follow the current standard 30-day notification time frame, measured from the date that the health care network is notified of the delegate's agreement with the subdelegate.

Agency Response. The department declines to make the suggested change because it is unnecessary. Insurance Code §1305.102(a) already provides that a network may not enter into a contract with another network for management services unless the proposed contract is first filed with the department and approved by the Commissioner. Also, Insurance Code §1305.154(c)(11) already provides that a network's contract with a carrier must include a provision that requires the network to provide to the department the license number of a management contractor or any delegated third party who performs a function that requires a license as a utilization review agent under Chapter 4201 or any other license under the Insurance Code or another insurance law of this state.

Comment on §10.42

Comment. A commenter supports the changes that require billing and payment to comply with rules governing billing and payment for maximum medical improvement and impairment rating. The commenter states that this change will ensure that providers and certified networks comply with billing and payment requirements.

Agency Response. The department appreciates the support.

Comment on §10.42(b)(2)

Comment. A commenter expresses support for the closed formulary adopted by the Division of Workers' Compensation under §134.540. The commenter states that, as provider contracts are largely standardized across states and products, there are no state-specific statutory references contained in the main contract itself, which allows for operational efficiency. For this reason, the commenter suggests that §10.42(b)(2) be clarified to note that reference to the specific Texas formulary by rule number is not necessary in the text of the provider contract, as long as the provider contract refers to compliance with state formularies as applicable by state law as a condition of contracting.

Agency Response. The department declines to remove the specific Texas formulary references. While the department understands that generic contracts can be used across states and products, this rule addresses workers' compensation coverage, and the applicable reference is necessary. This reference provides clarity to participants in the state of Texas workers' compensation system, and that benefit outweighs any burden to include the specific references, which the department believes to be minimal anyway.

Comment on §10.42(b)(13)

Comment. A commenter acknowledges that §10.42(b)(13) has been modified to add a requirement that network contracts include a statement that provider billing and payments will be made in compliance with rules governing the billing and payment for certification of maximum medical improvement and impairment rating examinations. The commenter states that each health care network provider is contractually required to comply with all applicable federal and state laws and regulations as a standard term of engagement. The commenter states that its Texas contracts currently mention the Labor

Code and DWC rule requirements for maximum medical improvement and impairment rating training. The commenter recommends clarifying §10.42(b)(13) to state that specific reference to the billing and payment for MMI/IR is not required, as long as the provider contract references compliance with state law generally as a condition of provider contracting.

Agency Response. The department disagrees with removing the reference to Labor Code §408.027 and rules governing the billing and payment for certification of maximum medical improvement and impairment rating examinations. While the department understands that generic contracts can be used across states and products, this rule addresses workers' compensation coverage, and the applicable reference is necessary. This reference provides clarity to participants in the state of Texas workers' compensation system, and that benefit outweighs any burden to include the specific references, which the department believes to be minimal anyway.

Comment on §10.42(b)(15)

Comment. A commenter states that, although an insurer may not deny payment for services provided before the issuance of the notice that the injury was not compensable, Insurance Code §1305.153(e) sets a $7,000 cap on such reimbursements. The commenter says that §10.42(b)(15) should state the $7,000 maximum reimbursement amount.

Agency Response. The department declines to make the change because it believes repeating the statutory language in the rule text is unnecessary.

Comment on §10.60

Comment. A commenter recommends that the employee notification requirements of §10.60 be triggered at the time of injury only. The commenter believes that requiring notification of the health care network at the time of injury only would greatly reduce unnecessary notice and record-keeping burdens on employers and would likely promote greater use of a health care network.

Agency Response. The department declines to make the recommended change. The timing requirements for employee notification are set in Insurance Code §1305.005 and §1305.103.

Comment on §10.60(d)(1)

Comment. A commenter suggests removing the "10 percent or more" threshold for requiring the acknowledgment form to be provided in a language other than English and Spanish. The commenter states that as the Texas workforce becomes more diverse, the "10 percent or more" threshold will exclude some non-English speakers from receiving notice of network requirements. The commenter also states that it is not clear whether the 10 percent refers to a geographic location or the total number of employees at the employer, and that the threshold is not required by Insurance Code §1305.005 or §1305.041.

Agency Response. The department declines to make the suggested change. The department did not propose changes to §10.60(d)(1), thus the commenter's suggestions are outside the scope of the proposed rules.

Comments on proposed §10.60(g)

Comments. Twenty-five commenters object to the provision in §10.60(g) allowing a carrier and employer to determine which of the two is responsible for obtaining a signed employee acknowledgment form, stating that the provision is in conflict with and not permitted under Insurance Code §1305.005. The commenters state that after the passage of the 2005 Workers' Compensation Act, and during the original rulemaking process, the department recognized that the Insurance Code named the employer as the party responsible for delivering notice of network requirements to employees. The commenters state that the proposed change appears to contradict a prior agency position.

Another commenter states that the proposed changes would make Insurance Code §1305.103(c) meaningless. The commenter also states that mailing the notice to an injured employee has not been considered proper notice in the past, and no change in the law has taken place to initiate such a change. The commenter says that the department stated in the original adoption order that even a certified mail receipt cannot be considered proper notice. The commenter states that a carrier cannot truthfully document a refusal when an employee does not return the mailed acknowledgment form. The commenter cites §10.60(j) to provide that a standardized documentation of delivery of notice must contain the delivery date, delivery location, and to whom the notice was delivered. The commenter states that mailing the notice cannot possibly satisfy these requirements since mailing and delivery are different. The commenter further states that part of the employer's responsibility to notify employees under Insurance Code §1305.005(d) is to post a notice of network requirements at each place of employment. If an agreement that the carrier is responsible for the network notice is reached, it is then incumbent on the carrier to go to each place of employment and post the required notice.

Some commenters say they fail to see the need for this amendment to §10.60. The commenters state that its adoption would likely lead to confusion about who has responsibility for network notification.

A few commenters state that Insurance Code §1305.005(d), (e), and (g) clearly state that the employer must provide notice of network requirements at the time of hire and after notice of an injury. The commenters oppose the proposed rule changes to §10.60(g) because they say (1) the changes go beyond the agency's assigned rulemaking and changes the law, (2) it will create an undue burden on injured employees and make their understanding of the rules more difficult, (3) it will create more confusion regarding the process, and (4) that there is no compelling reason for the rule changes. The commenters also state the proposed rule will increase taxpayer cost.

Some commenters state that the employer should remain the responsible party for delivering the notice of network requirements and obtaining the employee's signature of receipt. The commenters state that the employer already has a relationship with the employee, and since it is typically done in person, the injured employee can ask questions, if needed. The commenters state that, in their experience, many of the employees have a limited understanding of workers' compensation insurance matters and have questions. The commenters state that, given the lack of a prior relationship and an injured employee's skepticism of the insurance carrier, it would be a disservice to an injured employee to have the carrier supply this notice through a remote method such as mail, email, or a telephone conversation. The commenters state as well that the proposal would also increase the cost to the department, and the taxpayer, as it mandates additional record keeping.

One commenter recommends additional changes to include a deadline for the carrier and employer to reach an agreement and to obtain a signed acknowledgment form. The commenter states that an untimely agreement might delay providing notice of network requirements to the employees. The commenter states that delays in providing notice deprive employees of their rights under the law.

Agency Response. In response to these comments, the department has removed proposed §10.60(g) and its requirement for an employer and carrier to determine which party will be responsible for obtaining a signed acknowledgment form from the text as adopted and has also not adopted the references to "responsible party" in adopted §10.60(b), (c), (e), (i), (j), and (k).

Comment on proposed §10.60(i)(14)(A) (which is adopted as §10.60(h)(14)(A))

Comment. A commenter states that, because of the fluid nature of the emerging practice of telemedicine, and providers adopting telemedicine processes on either a temporary or permanent basis, and perhaps, at times, disengaging from telemedicine, it is not possible to state categorically whether a provider may be offering telemedicine services at a particular time. The commenter recommends that the references to telehealth service, telemedicine service, and teledentistry dental service not be included in the adopted text.

Agency Response. The department disagrees with removing the references to telehealth service, telemedicine service, and teledentistry dental service from the rule text. Telehealth services, telemedicine services, and teledentistry dental services are being utilized by patients more frequently, and often are the preferred method of engagement for many providers and patients. For this reason, the department believes this information should be included in the list of network providers.

Comment on proposed §10.60(k)

Comment. A commenter states that the statute does not require an employee to sign the acknowledgment form, and because of this, the employer or carrier should not be required to retain signed forms as specified in proposed §10.60(k). The commenter proposes alternative text to effectuate its recommendation.

Agency Response. The department has removed proposed subsection (k) from the text of §10.60 in response to this comment. The department acknowledges that Insurance Code §1305.005(f) does not require a signed acknowledgment form for the network requirements to be applicable, provided that the employee receives the notice and acknowledgment form as required by Insurance Code §1305.005(d)(1) and §10.60(g).

Comment on §10.61

Comment. A commenter opposes the proposed deletion of §10.61(d). The commenter says that deleting subsection (d) would remove the ability of an employee and network to agree that the employee may participate in a network even though the employee does not live within the network service area. The commenter states that subsection (d) is beneficial to injured workers because it gives them more opportunities for appropriate treatment. The commenter states this is particularly true for injured workers who live in rural areas outside a network service area but work in urban areas inside the network service area. The commenter states that these workers often choose to receive treatment with network providers near their workplace, and giving such workers this option provides more opportunities for treatment. The commenter also states that deletion of subsection (d) is not required by Insurance Code §1305.451.

Agency Response. The department agrees to not delete §10.61(d).

Comments on §10.80(g)(4), (5), and (6)

Comment. A commenter opposes new paragraphs (5) and (6) because they would impose burdensome documentation requirements on networks that exceed the requirements of Insurance Code §1305.301 and §1305.302. The commenter says the rule should require only that networks demonstrate good faith attempts to obtain provider contracts as required by Insurance Code §1305.302(h)(2).

Another commenter says that a health care network would be required to submit significant detail related to contracting efforts in service areas where the department has determined the health care network has not met availability and accessibility standards under proposed §10.80(g)(4)(A) and (B), (g)(5)(A) and (B), and (g)(6)(A) and (B). The commenter states that while it appreciates that the department is working diligently to ensure that the needs of injured workers in the state are being met by requiring outreach efforts to providers in less-served areas, the proposed language should be streamlined to require a more general overview of contracting efforts within a service area to protect the proprietary nature of the contracting process. The commenter suggests as an alternative that if detailed contact information in underserved areas continues to be required, the rules should be clarified to mandate that detailed documentation needs to be included only on a prospective basis and only at such time as when the health care network undergoes a material modification to a network service area.

The commenter also states that the rules should be clarified to mandate that any information shared with the department under these sections would be kept confidential

and out of the public record to protect the proprietary and competitive nature of contracting with providers across the state.

Agency Response. The department disagrees with deleting or limiting the requirements in §10.80(g)(4), (5), and (6). Networks should be able to provide the information in §10.80(g)(6), which includes a list of physicians, providers, and facilities within the service area with whom they attempted to contract but were unsuccessful. Without a list, the department cannot determine that a good faith effort to contract was made. Under §10.80(g)(4), an access plan must include a network development and contracting plan. The department needs this information to ensure the network can provide all necessary care to injured employees, and provide a plan for how care will be made available when a contracted provider is not available in the service area. The contracting plan can include elements such as continued attempts to contract with providers in the service area, case by case arrangements for specific injured employees, and when there is a gap in the network's availability and accessibility. Similarly, the department needs the information specified in §10.80(g)(5) in order to approve an access plan for a nonrural county without a hospital contract. The required information can show whether the network made a good-faith effort to contract with the available facilities, and whether alternative facilities are available to provide the necessary care for an injured employee.

Also, in response to the comment regarding the prospective submission of information, the department notes that the lists required in §10.80(g)(5) and (6) must be provided after the effective date of this rule. In addition, while the department is not authorized to make records confidential by rule, it will follow the requirements of the Public Information Act (Government Code Chapter 552) and any other relevant laws.

Comment on §10.80(g)(5)(B)

Comment. A commenter requests that the department define and clarify which facilities would be "nonacute care facilities that can provide required acute hospital services" under §10.80(g)(5)(B). The commenter asks if urgent care facilities, freestanding ERs, walk-in clinics, ambulatory surgical centers, and the like would be included within this definition.

Agency Response. Examples of acute hospital services include emergency care, intensive care, coronary care, cardiology, and neonatal intensive care. However, the department is unable to definitively confirm that urgent care facilities, freestanding ERs, walk-in clinics, ambulatory surgical centers, and other similar facilities meet the standard in §10.80(g)(5)(B) because the department does not license facilities or regulate what services each can provide.

Comment on §10.81

Comment. A commenter supports the proposed changes to §10.81 requiring certified networks to maintain documentation demonstrating that doctors who provide certifications of maximum medical improvement and impairment rating to an injured employee are authorized to do so under Division of Workers' Compensation rules.

Agency Response. The department appreciates the support.

Comment on §10.82

Comment. A commenter expresses support for §10.82 as proposed because it simplifies the credentialing requirements within the health care networks, which would be an extremely positive change for networks in Texas. The commenter states that this would align Texas requirements and workflows with the credentialing practices and standards

accepted across the country. Also, under these updated credentialing standards, the site visit requirement would be removed, which is also in line with national guidelines.

Agency Response. The department appreciates the support.

Comments on §10.82

Comment. A commenter requests that the department not require networks to provide credentialing information. The commenter explains that this is a manual process to complete and is administratively burdensome. The commenter states that with the revised credentialing requirements, a networks' NCQA/JCAHO/URAC accreditations should be considered by the state to be sufficient to demonstrate that providers within the network are appropriately credentialed, without a redundant separate listing of credentialing detail.

Another commenter states opposition to new §10.82(a) because it would impose new, unpublished credentialing standards that networks are unable to evaluate if they do not have access to them by virtue of being accredited or certified by NCQA or URAC. The commenter requests that the department publish the credentialing standards promulgated by those two entities so that networks that are not accredited by them can properly evaluate whether the proposed credentialing standards are feasible.

Agency Response. The department declines to remove the requirement in §10.82(a) to provide credentialing information to the department when requested. The department wants to make certain networks are following the credentialing requirements for their provider panels. The department does not require that the information be provided annually, but only upon request by the department. This limitation should reduce the burden on networks. The department also disagrees with the recommendation to publish

the credentialing standards promulgated by NCQA and URAC because the credentialing standards are proprietary, and the department does not have permission to post or publish them. However, the standards are available from the accrediting bodies for a minimal cost and can be purchased separately from accreditation. Most of the networks also do group health and will already have access to the standards, as they are required to use the standards in group health.

Comments on §10.82(d)

Comment. A commenter requests a change to §10.82(d), which sets a deadline of September 23, 2022, for compliance with the proposed credentialing standards. The commenter states that networks will need time to revise their credentialing processes to comply with the new standards, and the deadline of September 23, 2022, may not provide enough time for compliance. The commenter requests that the department revise subsection (d) to provide 180 days for compliance. The commenter proposes alternative text to effectuate its recommendation. Another commenter requests that the compliance date be set for 12 months after final adoption of the rules.

Agency Response. The department agrees to make a change to subsection (d) as adopted and has changed the compliance deadline to January 1, 2023. The department declines to change the compliance deadline to 12 months after the adoption date because it does not believe it will require 12 months for networks to be compliant. The amended credentialing standards streamline the process by eliminating several outdated procedures currently being performed by networks. The re-credentialing time frames remain in place. The change will be in credentialing any new providers using the streamlined, nationally accredited processes.

Comment on §10.101

Comment. A commenter opposes §10.101(d) because the provision can be read to mean that only doctors and dentists may perform utilization review and nurses may not do so. The commenter states that the second sentence states that physicians, doctors, and other health care providers conducting utilization review "must have the appropriate credentials as required by Chapter 180," and the relevant rule in Chapter 180 appears to be 28 TAC §180.1(4), which defines "appropriate credentials," and which mentions only physicians, dentists, and chiropractors. The commenter asks the department to revise §10.101(d) to clarify that the subsection does not prohibit nurses from performing utilization review on initial requests where no adverse determination is issued. The commenter proposes alternative text to effectuate its recommendation.

Agency Response. The department declines to make the requested change. The language in §10.101(d) is consistent with the language in the utilization review rules under §10.200(a).

Comment on §10.120(b)

Comment. A commenter states that §10.120(b) references a "network's failure to pay." The commenter states that this language should be modified because in many cases the health care network is not the payor. The commenter explains that, although a health care network provider would be very involved in managing the research and response to the fee dispute and ensuring the payment level recommended is appropriate, the payment itself would be made by the health care network insurer.

Agency Response. The department agrees and has changed the language to delete the words "the network."

Comment on §10.121(e)

Comment. A commenter requests clarification on the meaning of the term "complaint appeal."

Agency Response. The department has removed "complaint appeal" from the adopted rule. The language now states that each network must maintain the required complaint-and-appeal log and documentation on each complaint, appeal, complaint proceeding, and action taken on the complaint until the third anniversary after the date the complaint was received.

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

STATUTORY AUTHORITY. The Commissioner adopts amendments to §10.1 and §10.2 and new §10.3 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 the department under the Insurance Code and other laws of this state.

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.

(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 (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) 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.

(e) 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, to contract directly with a workers' compensation health care network for the provision of health care services to injured employees.

(f) 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 remain in full effect.

§10.2. Definitions.

(a) The following words and terms when used in this chapter 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.

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

(4) 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.

(5) Complainant--Has the meaning assigned by Insurance Code §1305.004.

(6) Complaint--Has the meaning assigned by Insurance Code §1305.004.

(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) Credentialing--Has the meaning assigned by Insurance Code §1305.004.

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

(10) Emergency--Has the meaning assigned by Insurance Code §1305.004.

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

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

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

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

(15) Independent review organization--Has the meaning assigned by Insurance Code §1305.004.

(16) Life-threatening--Has the meaning assigned by Insurance Code Chapter 4201, concerning Utilization Review Agents.

(17) Live or lives--Where an employee lives includes:

(A) the employee's principal residence for legal purposes, including the physical address that 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) Medical emergency--Has the meaning assigned by Insurance Code §1305.004.

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

(21) Mental health emergency--Has the meaning assigned by Insurance Code §1305.004.

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

(23) 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) Person--Has the meaning assigned by Insurance Code §1305.004.

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

(26) 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.

(27) Provider--A health care provider.

(28) Quality improvement program--Has the meaning assigned by Insurance Code §1305.004.

(29) 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.

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

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

(32) Screening criteria--Has the meaning assigned by Insurance Code §1305.004.

(33) Service area--Has the meaning assigned by Insurance Code §1305.004.

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

(35) Transfer of risk--Has the meaning assigned by Insurance Code §1305.004.

(36) Utilization review--Has the meaning assigned by Insurance Code Chapter 4201.

(37) Utilization review agent or URA--Has the meaning assigned by Insurance Code Chapter 4201.

(b) When used 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) injury;

(13) insurance carrier;

(14) maximum medical improvement; and

(15) 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 Commissioner adopts amendments to §§10.20 - 10.27 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 the department under the Insurance Code and other laws of this state.

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, 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; or

(2) the MCQA mailing address.

§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), 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, and §10.41 and §10.42 of this title (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 of this title (relating to Network-Carrier Contracts);

(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;

(6) each management contract as described in §10.40 of this title (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, and Chapter 10, Subchapter G, of this title (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, and §10.81 of this title (relating to Quality Improvement Program);

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

(D) the utilization review program described in Insurance Code Chapter 1305, Subchapter H, concerning Utilization Review, and Chapter 10, Subchapter F, of this title (relating to Utilization 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, and §10.80 of this title (relating to Accessibility and Availability Requirements). This description must 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) 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) information indicating whether each network provider is accepting new patients from the workers' compensation health care network;

(E) 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) 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 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 (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 (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, and be designed to reduce inappropriate or unnecessary health care while safeguarding necessary care, as required under Insurance Code §1305.304 and §10.83(a) of this title; 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 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 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 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 (relating to Network-Carrier Contracts); and

(2) the department by sending the financial statement to the department's workers' compensation network email address.

§10.25. Filing Requirements.

(a) A network must 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 (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).

(b) A network must file an 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) A network must 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. 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. 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 (relating to Contents of Application);

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

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

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

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

(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;

(2) the department's workers' compensation network email address; or

(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 (relating to Contents of Application);

(2) network configuration information, as required by §10.22(11) of this title; 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 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;

(2) the department's workers' compensation network email address; or

(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 Commissioner adopts amendments to §§10.40 - 10.42 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 the department under the Insurance Code and other laws of this state.

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 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) A network's contract with a carrier must 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 of Workers' Compensation;

(3) a provision that the contract:

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

(B) must be terminated immediately if cause exists;

(4) a hold-harmless provision stating that the network, a management contractor, a third party to which the network delegates a function, and the network's contracted providers are prohibited from billing or attempting to collect any amounts from an employee for health care services for compensable injuries under any circumstances, including the insolvency of the carrier or the network;

(5) a statement that the carrier and the network retain 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 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;

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

(E) 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;

(12) an acknowledgment 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 (relating to Notice of Network Requirements; Employee Information) to employers or employees;

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

(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.

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

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

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

(c) A network must not act as a network for any entity regarding an insurance plan 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 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 (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 be resolved through the complaint resolution process under Insurance Code Chapter 1305, Subchapter I, concerning Complaint Resolution, and Subchapter G of this title (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 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 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;

(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 (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 Commissioner adopts amendments to §§10.60 - 10.63 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 the department under the Insurance Code and other laws of this state.

TEXT.

§10.60. Notice of Network Requirements; Employee Information.

(a) An insurance carrier that establishes or contracts with a network must deliver to the employer, and the employer or carrier, as applicable under subsection (g) of this section, must 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) 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 may:

(1) 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.

(c) The carrier must provide to the employee all information required by Insurance Code §1305.451. The notice must include an employee acknowledgment form and comply with all requirements under subsections (d) - (i) of this section, as applicable.

(d) 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 (relating to Plain Language Requirements); and

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

(e) The insurance carrier and employer may use an employee acknowledgment form that complies with this section or a sample acknowledgment form that may be obtained from the department's website.

(f) 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) The employer must 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), concerning Treating Doctor; Referrals, and subsection (b) of this section must obtain a signed employee acknowledgment form from that employee. For purposes of this subsection, an employer or carrier, as applicable, may obtain an acknowledgment of the notice required under this section through electronic means from an employee who makes an electronic signature in accordance with applicable law.

(h) 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 (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 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 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 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 (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 be identified and listed separately from specialists. Providers who are authorized to assess maximum medical improvement and render

impairment ratings and providers who provide a telehealth service, telemedicine medical service, or teledentistry dental service must 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.

(i) An employer or carrier, as applicable, must 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.

(j) The failure of an employer or carrier, as applicable, to establish a standardized process for complying with subsection (i) of this section creates a rebuttable presumption that the employee has not received the notice of network requirements and is not subject to network requirements.

(k) 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 obtain medical treatment for a compensable injury from in-network providers, except as provided in Insurance Code §1305.006(1) and (3), concerning Insurance Carrier Liability for Out-of-Network Health Care; subsection (e)(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 (relating to Dispute Resolution for Employee Requirements Related to In-Network Care).

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

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

(f) An insurance carrier that establishes or contracts with a network is liable for in-network health care for a compensable injury that is provided to an injured employee in accordance with Insurance Code Chapter 1305, 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 approve or deny a referral to an out-of-network provider within the time appropriate under the circumstances, but, under any circumstance, not later than seven days after the date the referral is requested;

(B) if the network denies the referral request under subsection (a) of this section because the requested service is available from network providers, the employee may file a complaint in accordance with the network's complaint process under Insurance Code §1305.402, concerning Complaint Initiation and Initial Response; Deadlines for Response and Resolution, and §10.121 of this title (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 (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 (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 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 provide the employee with the notice of network requirements as described under §10.60 of this title (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 notify the employee, in writing, of the carrier's determination. This notice must 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 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 (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 (relating to Notice of

Network Requirements; Employee Information) must be written in plain language and comply with the following requirements:

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

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

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

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

STATUTORY AUTHORITY. The Commissioner adopts amendments to §§10.80 - 10.86 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 the department under the Insurance Code and other laws of this state.

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

(1) 75 miles in nonrural areas; and

(2) 75 miles in rural areas.

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

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

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

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

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

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

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

(3) documentation that demonstrates how the network determined that providers are not located within the required distances;

(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 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 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 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 include return-to-work and medical case management programs. The network must 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 develop a written description of the quality improvement program that outlines the program's organizational structure, functional responsibilities, and committee meeting frequency;

(2) Work plan. The network must 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 include:

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

(B) evaluation of each program, including:

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

(ii) continuity of health care and related services;

(iii) clinical studies;

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

(v) employee and provider satisfaction;

(vi) the complaint-and-appeal process, complaint data, and identification and removal of communication barriers that 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 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 prepare an annual written report on the quality improvement program that 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, The Joint Commission, URAC, or the Accreditation Association for Ambulatory Health Care;

(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;

(4) the national accreditation organization's requirements are the same as, 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:

(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 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:

(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 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, 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 work with providers, employees, doctors, and employers to facilitate cost-effective health care and the employee's return to work, and must be certified in one or more of the following areas:

(1) case management;

(2) case management administration;

(3) rehabilitation case management;

(4) continuity of care;

(5) disability management; or

(6) occupational health.

§10.82. Credentialing.

(a) 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.

(c) Delegation of credentialing.

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

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

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

(d) Compliance. Until January 1, 2023, 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 January 1, 2023.

§10.83. Guidelines and Protocols.

(a) Each network must adopt treatment guidelines, return-to-work guidelines, and individual treatment protocols, which must be evidence-based, scientifically valid, outcome-focused, and be 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, through its quality improvement program under §10.81 of this title (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 contractually require providers to follow treatment guidelines, return-to-work guidelines, and individual treatment protocols pursuant to §10.42(b)(2) of this title (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 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; 408.023(l) - (p), concerning List of Approved Doctors; Duties of Treating Doctors; and rules adopted by the Commissioner of Workers' Compensation.

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

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

§10.86. Telephone Access.

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

STATUTORY AUTHORITY. The Commissioner adopts amendments to §§10.100, 10.101, and 10.104 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 the department under the Insurance Code and other laws of this state.

TEXT.

§10.100. Applicability.

In addition to the requirements under this subchapter, the requirements of Insurance Code Chapter 4201, concerning Utilization Review Agents, apply to utilization review conducted in relation to a workers' compensation health care network. In the event Chapter 4201 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.

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

(b) The carrier's utilization review program must include a process 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; 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) 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; 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.

(c) A requestor must timely file a request for independent review under subsection (b) 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) The insurance carrier must pay for the independent review provided under this subchapter.

(e) The department will assign the review request to an independent review organization.

(f) 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 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) If review is not sought under subsection (g) of this section, the carrier and network must 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 Commissioner adopts the repeals of §10.102 and §10.103 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 the department under the Insurance Code and other laws of this state.

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 Commissioner adopts amendments to §§10.120 - 10.122 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 the department under the Insurance Code and other laws of this state.

TEXT.

§10.120. Complaint System Required.

(a) Each network must implement and maintain a complaint system compliant with Insurance Code Chapter 1305, Subchapter I, concerning Complaint Resolution, 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 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 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 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 issue a resolution letter to the complainant not later than the 30th calendar day after the network receives the written complaint that:

(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;

(4) explains the network's procedures and deadlines for filing an appeal of the complaint; and

(5) 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 (relating to Submitting Complaints to the Department).

(d) A network must maintain a complaint-and-appeal 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;

(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 log required under subsection (d) of this section and documentation on each 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 the department's website.

SUBCHAPTER H. EXAMINATIONS
28 TAC §10.200

STATUTORY AUTHORITY. The Commissioner adopts amendments to §10.200 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 the department under the Insurance Code and other laws of this state.

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 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 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 the part of the annual salary attributable to each hour the examiner examines the network.

(2) The expenses included in an examination fee are 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.

(c) An examination fee paid pursuant to this section is payable and due to the Texas Department of Insurance at the address given on the invoice no later than 30 days from the invoice date.

CERTIFICATION. This agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on July 12, 2022.

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

The Commissioner adopts the repeal of §10.102 and §10.103; new §10.3; and amendments to §§10.1, 10.2; 10.20 - 10.27, 10.40 - 10.42, 10.60 - 10.63, 10.80 - 10.86, 10.100, 10.101, 10.104, 10.120 - 10.122, and 10.200.

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Cassie Brown
Commissioner of Insurance

Commissioner's Order No. **2022-7378**