Workers' Compensation Health Care Network Application

Instructions

Applicants for Original Certification and Certified Workers' Compensation Health Care Networks (Network) must use this application form for the following types of applications:

- Original Application
- Modifications to Service Area
- Material Modifications to Network Configuration
- Changes To Application Exhibits (Subsequent Filings)

1. Original Application

- **Fields:** Complete **all sections and fields** in the application.
- **Exhibits:** Submit **all exhibits** listed in the section titled "**Required Exhibits for an Original Application**."
- **Filing Fee:** Submit $5,000 filing fee with the application, payable to the Texas Department of Insurance.

2. Modifications to Service Area (Reduction or Expansion of Service Area)

Modifications to the service area require the Texas Department of Insurance's (department) approval **prior to** implementing the modification. See 28 Texas Administrative Code (TAC) Section 10.26. Complete all fields in Sections 1, 2, and 3. **If applicable**, complete any field in the application form that is no longer current as stated in the original application or the last application that the network submitted. Submit all exhibits listed in the section titled "**Required Exhibits for Modifications to Service Area**."

3. Material Modifications to Network Configuration

Material modifications to network configuration (material changes to physician and provider network) require the department's approval **prior to** implementing the modification. See 28 TAC Section 10.27. Complete all fields in Sections 1, 2, and 3. **If applicable**, complete any field in the application form that is no longer current as stated in the original or the last application that the network submitted. Submit all exhibits listed in the section titled "**Required Exhibits for Material Modifications to Network Configuration**."

4. Changes to Application Exhibits (Subsequent Filings)

After certification, a network must file any information that amends, supplements, or replaces the items previously filed with the department. Several exhibits must be filed for approval before implementation and others are filed for information. See 28 TAC Section 10.25. Complete all fields in Sections 1, 2, and 3. **If applicable**, complete any field in the application form that is no longer current as stated in the

original or the last application that the network submitted. If the network submits a subsequent filing, the network must fill out the exhibits list titled "**Changes to Application Exhibits (Subsequent Filings)**" to identify the exhibits the network is submitting for this purpose.

5. Additional Instructions for All Applications

- Completeness**:** Do not leave blank fields and enter "NA," when appropriate.
- Formatting**:** (1) Use letter or legal-size white paper, (2) Type the information (3) Do not highlight any areas, (4) Mark all exhibits clearly by using a cover page or tab, (5) Number all pages of the documents submitted with the application, (6) Submit only one copy of application and exhibits, and (7) Attach the applicable exhibits list in front of the exhibits.
- To access all MCQA forms referenced in this application, go to the forms page at the following links: MCQA forms.

6. Where to send Application

Email: WCAppCoordinator@tdi.texas.gov

Or by mail to:

Texas Department of Insurance
MCQA Office, MC-LH-MCQA
PO Box 12030
Austin, Texas 78711-2030

Application Information

1. Type of Application (check the box that applies)

- ☐ Original Application, with $5000 Filing Fee
- ☐ Modifications to Service Area (No Fee)
- ☐ Material Modifications to Network Configuration (No Fee)
- ☐ Changes to Application Exhibits (No Fee)

2. Organizational Information

Type of entity and name, and, if applicable, department license or certificate number. This number is not applicable to the original application filing.

Workers' Compensation Carrier _____

HMO _____

PPO _____

Physician / Provider Group _____

Utilization Review Agent _____

Other _____

Name of Applicant[1] _____

DBA Name - If applicant intends to use a DBA, then the applicant must submit evidence of DBA filing.

_____

Mailing Address

_____

Official Email Address

_____

Telephone Number and Fax Number

_____

Physical Address (if different from mailing address)

_____

Telephone Number and Fax Number (if different from numbers entered for mailing address)

_____

Applicant/network's Federal Employer Identification Number _____

Date and State of Incorporation _____

Type of Organization (Corporation, Partnership, LLC, etc.) _____

If the applicant / network currently holds a certificate of authority in Texas, provide company number and, if applicable, NAIC number _____

Has your company ever been denied certification or licensure in this or any other state prior to the date of this application?

☐ No ☐ Yes If yes, provide explanation in a separate page and attach it to the application.

Are you currently licensed as a Workers' Compensation Health Care Network in another state?

☐ No ☐ Yes If yes, State _____ License #_____ Date of Licensure _____

List all other applications filed by the applicant which are pending before the department (if applicable).

Name	**Type**
_____	_____
_____	_____

[1] A network is not an insurer and may not use in the network's name or informational literature the word "insurance," "casualty," "surety," or "mutual" or any other word that is descriptive of the insurance, casualty, or surety business; or deceptively similar to the name or description of an insurer or surety corporation engaging in the business of insurance in this state.

3. Contact Information

Company contact for application (answers questions about the information in the application)

Name and Title _____

Mailing Address _____

Email Address _____ Phone _____ Fax _____

Company contact for financial information:

Name and Title _____

Mailing Address _____

Email Address _____ Phone _____ Fax _____

Company contact for complaints:

Name and Title _____

Mailing Address _____

Email Address _____ Phone _____ Fax _____

4. Service Arrangements

Delegation: List the names of the third-party that will perform any of the following services or functions on behalf of the network. If more than one third party performs the same function, list all names. If necessary, please use a separate page and attach it to the application.

Function number	Name of third-party	Business address	Primary contact and phone number
1. Credentialing			
2. Contracting			
3. Quality Improvement			
4. Network Management			
5. Complaints			

If a workers' compensation carrier delegates any of the functions listed below **to the applicant**, enter name of carrier in the table below. If more than one carrier, list all carriers. If necessary, please use a separate page and attach it to the application.

Function	Carrier Name	Business address	Primary contact and phone number
1. Utilization Review			
2. Claims (TPA Functions)			
3. Bill Review			
4. Other			

5. Officers' Certification and Attestation:

The authorized representative of the Applicant must read the following statements and sign where indicated:

I hereby certify, under penalty of perjury, that I have read the application, that I am familiar with its contents, and that all the information, including the attachments, submitted in this application is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license discipline or other administrative action and may subject me, the Applicant, or both, to civil or criminal penalties.

1. I acknowledge that I am familiar with the insurance and workers' compensation laws and regulations of the jurisdictions in which the Applicant is certified or to which the Applicant is applying for certification.
2. I acknowledge that I am authorized to execute and am executing this document on behalf of the Applicant.
3. Applicant acknowledges that lawful process in a legal action or proceeding against the network on a cause of action assigned in this state is valid if served in the manner provided by Texas Insurance Code Chapter 804 for a domestic company.
4. I hereby certify under penalty of perjury under the laws of the applicable jurisdictions that all of the foregoing is true and correct.

Authorized Representative Signature _____ Title _____

Print Name _____ Date _____

The State of _____

County of _____

Before me, _____, a notary public in and for the State of _____, on this day personally appeared _____, known to me (or proved to me on the oath of _____ or through _____ to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that they executed the same for the purpose and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____ 20____ .

_____

Notary Public Signature

_____

Print Name

Affix Seal here

Required Exhibits for an Original Application

Complete the exhibits list by marking the boxes on the left side of the page prior to submitting your application for review. Place the completed exhibits list as the first page of your application package. For a complete description of all network requirements, see Texas Insurance Code Chapter 1305 and department rule in 28 TAC Chapter 10. Find all statues and rules.

Exhibit 1. ☐ Organizational Documents 28 TAC Section 10.22(1):

- ☐ Organizational Chart or List
- ☐ Attorney for Service Form NAIC Form 12. If the applicant is not incorporated in the State of Texas, the applicant must submit TDI Attorney for Service form (TDI Form FIN312)
- ☐ Secretary of State Certificate of Formation

Exhibit 2. ☐ Biographical Documents 28 TAC Section 10.22(2):

- ☐ Officers and Directors Page (TDI Form FIN306)
- ☐ Biographical Affidavits (NAIC UCAA Form 11)
- ☐ Fingerprints: Fingerprint instructions

Exhibit 3. ☐ Form of the Provider Contract 28 TAC Section 10.22(3) and 10.42; TIC Chapter 1305.152

Exhibit 4. ☐ Third Party Contract (**must submit the executed delegation contract**) 28 TAC Section 10.22(4), 10.41 and 10.42; TIC Chapter 1305.102

Exhibit 5. ☐ Form of the Network and Insurance Carrier Contract 28 TAC Section 10.22(5) and 10.41; TIC Chapter 1305.154

Exhibit 6. ☐ Management Contract 28 TAC Section 10.22(6) and 10.40; TIC Chapter 1305.102

Exhibit 7. ☐ Financial Information 28 TAC Section 10.22(7)

Exhibit 8. ☐ Acknowledgement of Lawful Process 28 TAC Section 10.22(8)

Exhibit 9. ☐ Map and Description of the Service Area 28 TAC Section 10.22(9)

Exhibit 10. ☐ Programs and Procedures 28 TAC Section 10.22(10)

- ☐ Complaint System TIC Chapter 1305.401 - 1305.404; 28 TAC Chapter 10, Subchapter G
- ☐ Quality Improvement Program TIC Chapter 1305.301 - 1305.304; 28 TAC Section 10.81
- ☐ Credentialing 28 TAC Section 10.81
- ☐ Utilization Review TIC Chapter 1305.351 - 1305.355; 28 TAC Chapter 10, Subchapter F
- ☐ Selection of Treating Doctor TIC Chapter 1305.104 and 1305.105; 28 TAC Section 10.60

Exhibit 11. ☐ Network Configuration 28 TAC Section 10.22(11); TIC Chapter 1305.301 - 1305.304; 28 TAC Section 10.80

Exhibit 12. ☐ Physical Location of Applicant's Books and Records 28 TAC Section 10.22(12)

Exhibit 13. ☐ Business Plan 28 TAC Section 10.22(13)

Exhibit 14. ☐ Financial Authorization Statement 28 TAC Section 10.22(14)

Exhibit 15. ☐ Plan for Provision of Care to Injured Employees Who Live Temporarily Outside the Service Area 28 TAC Section 10.22(15)

Exhibit 16. ☐ Plan for Provision of MMI/IR Services 28 TAC Section 10.22(16); Labor Code Section 408.023

Exhibit 17. ☐ Doctors' Financial Disclosures 28 TAC Section 10.22(17); Labor Code Section 408.023 and 413.041

Exhibit 18. ☐ Notice to Employees of Network Requirements and Acknowledgement Form 28 TAC Section 10.22(18); TIC Chapter 1305.451; 28 TAC Section 10.60

Exhibit 19. ☐ Monitoring Plan for Providers 28 TAC Section 10.22(19); TIC Chapter 1305.304; 28 TAC Section 10.83

Exhibit 20. ☐ Treatment Guidelines and Return to Work Guidelines 28 TAC Section 10.22(20); TIC Chapter 1305.304; 28 TAC Section 10.83(a)

Exhibit 21. ☐ Medical Director Certification 28 TAC Section 10.22(21)

Required Exhibits for Modifications to Service Area

Exhibit 9. ☐ Map and Description of the Service Area: 28 TAC Section 10.22(9) and 10.26(b)(1)

Exhibit 11. ☐ Network Configuration: 28 TAC Section 10.22(11), 10.26(b)(2), and 10.80

Exhibit 13. ☐ Business Plan: 28 TAC Section 10.22(13) and 10.26(b)(3)

Exhibit 18. ☐ Notice to employees of Network Requirements and Acknowledgement form: 28 TAC Section 10.22(18); TIC Section 1305.451; and 28 TAC Section 10.60

Required Exhibits for Material Modifications to Network Configuration

Exhibit 9. ☐ Map and Description of the Service Area: 28 TAC Section 10.22(9) and 10.26(b)(1)

Exhibit 11. ☐ Network Configuration: 28 TAC Section 10.22(11), 10.26(b)(2), and 10.80

Exhibit 18. ☐ Notice to Employees of Network Requirements and Acknowledgement Form: 28 TAC Section 10.22(18); TIC Section 1305.304; 28 TAC Section 10.83

Changes to Application Exhibits (Subsequent Filings)

Check all exhibits that apply to this application.

Exhibits Filed For Approval: 28 TAC Section 10.25(a)

Must file **30 days prior** to implementation.

- ☐ Management Contracts and information regarding fidelity bonds (Exhibit 6)
- ☐ Material Modification of Network Configuration (Exhibit 11) [**Must be filed as an application for modifications to network configuration, not as a subsequent filing**]
- ☐ Physical Location of Applicant's Books and Records (Exhibit 12)

Exhibits Filed for Information only:

Must file **30 days prior** to implementation of any change: 28 TAC Section 10.25(d)

- ☐ Notification of Network Sale, Merger, Change in Control or Organizational Change

Must file **30 days after** implementation of any change: 28 TAC Section 10.25(c)

Exhibit 1.
- ☐ Organizational Documents
- ☐ Organizational Chart or List
- ☐ Attorney for Service Form NAIC Form 12. If the applicant is not incorporated in the State of Texas, the applicant must submit TDI Attorney for Service form (TDI Form FIN312)
- ☐ Secretary of State Certificate of Formation

Exhibit 2.
- ☐ Biographical Documents
- ☐ Officers and Directors Page (TDI Form FIN306)
- ☐ Biographical Affidavits (NAIC UCAA Form 11)
- ☐ Fingerprints: See fingerprint instructions.

Exhibit 3.
- ☐ Form of the Provider Contract

Exhibit 4.
- ☐ Third Party Contract (**must file the executed delegation contract**)

Exhibit 5.
- ☐ Form of the Network and Insurance Carrier Contract

Exhibit 7.
- ☐ Financial Information

Exhibit 8.
- ☐ Acknowledgement of Lawful Process

Exhibit 9.
- ☐ Map of the Service Area

Exhibit 10.
- ☐ Programs and Procedures
- ☐ Complaint System
- ☐ Quality Improvement Program

- ☐ Credentialing
- ☐ Utilization Review
- ☐ Selection of Treating Doctor

Exhibit 11. ☐ Network Configuration (**non-material**)

Exhibit 13. ☐ Business Plan

Exhibit 14. ☐ Financial Authorization Statement

Exhibit 15. ☐ Plan for Provision of Care to Injured Employees who live temporarily outside the Service Area

Exhibit 16. ☐ Plan for Provision of MMI/IR Services

Exhibit 17. ☐ Doctors' Financial Disclosures

Exhibit 18. ☐ Notice to Employees of Network Requirements and Acknowledgement Form

Exhibit 19. ☐ Monitoring Plan for Providers

Exhibit 20. ☐ Treatment and Return to Work Guidelines

Exhibit 21. ☐ Medical Director Certification

** The network must file the information no later than 30 days after implementation of any change.

Questions

If you have questions or require assistance regarding completion of this form, email WCAppCoordinator@tdi.texas.gov or call 512-676-6400, select Option 5.

Your rights

You can request information we have about you by emailing OpenRecords@tdi.texas.gov or writing to: Public Information Coordinator, Texas Department of Insurance, PO Box 12030 (mail code GC-ORO) Austin, Texas 78711-2030. You also have the right to ask that we fix information we have about you that is wrong. To ask for a correction, send (1) your name, mailing address, and your phone number, (2) details about what needs to be fixed, and (3) the reason or proof showing why the information is wrong. Send this by email to RecordCorrections@tdi.texas.gov or by mail to: Record Correction Request, Texas Department of Insurance, PO Box 12030 (mail code CO-AAL-CC), Austin, Texas 78711-2030.