

INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE D. PROVIDER PLANS

CHAPTER 1305. WORKERS' COMPENSATION HEALTH CARE NETWORKS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1305.001. SHORT TITLE. This chapter may be cited as the Workers' Compensation Health Care Network Act.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.002. PURPOSE. The purpose of this chapter is to:

(1) authorize the establishment of workers' compensation health care networks for the provision of workers' compensation medical benefits; and

(2) provide 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:

(A) workers' compensation insurance carriers;

(B) employers certified to self-insure under Chapter 407, Labor Code;

(C) groups of employers certified to self-insure under Chapter 407A, Labor Code; and

(D) governmental entities that self-insure, either individually or collectively.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.003. LIMITATIONS ON APPLICABILITY. (a) This chapter does not affect the authority of the division of workers' compensation of the department to exercise the powers granted to the division under Title 5, Labor Code, that do not conflict with this chapter.

(b) In the event of a conflict between Title 5, Labor Code, and this chapter as to the provision of medical benefits for injured

employees, the establishment and regulation of fees for medical treatments and services, the time frames for payment of medical bills, the operation and regulation of workers' compensation health care networks, the regulation of health care providers who contract with those networks, or the resolution of disputes regarding medical benefits provided through those networks, this chapter prevails.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.004. DEFINITIONS. (a) In this chapter, unless the context clearly indicates otherwise:

(1) "Adverse determination" has the meaning assigned by Chapter 4201.

(1-a) "Administrator" has the meaning assigned by Section 4151.001.

(2) "Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, the person specified.

(3) "Capitation" means a method of compensation for arranging for or providing health care services to employees for a specified period that is based on a predetermined payment for each employee for the specified period, without regard to the quantity of services provided for the compensable injury.

(4) "Complainant" means a person who files a complaint under this chapter. The term includes:

- (A) an employee;
- (B) an employer;
- (C) a health care provider; and
- (D) another person designated to act on behalf of an employee.

(5) "Complaint" means any dissatisfaction expressed orally or in writing by a complainant to a network regarding any aspect of the network's operation. The term includes dissatisfaction relating to medical fee disputes and the network's administration and the manner in which a service is provided. The

term does not include:

(A) a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the complainant; or

(B) an oral or written expression of dissatisfaction or disagreement with an adverse determination.

(6) "Credentialing" means the review, under nationally recognized standards to the extent that those standards do not conflict with other laws of this state, of qualifications and other relevant information relating to a health care provider who seeks a contract with a network.

(7) "Emergency" means either a medical or mental health emergency.

(8) "Employee" has the meaning assigned by Section [401.012](#), Labor Code.

(9) "Fee dispute" means a dispute over the amount of payment due for health care services determined to be medically necessary and appropriate for treatment of a compensable injury.

(10) "Independent review" means a system for final administrative review by an independent review organization of the medical necessity and appropriateness, or the experimental or investigational nature, of health care services being provided, proposed to be provided, or that have been provided to an employee.

(11) "Independent review organization" means an entity that is certified by the commissioner to conduct independent review under Chapter [4202](#) and rules adopted by the commissioner.

(12) "Life-threatening" has the meaning assigned by Chapter [4201](#).

(13) "Medical emergency" means the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the patient's health or bodily functions in serious jeopardy; or

(B) serious dysfunction of any body organ or part.

(14) "Medical records" means the history of diagnosis and treatment for an injury, including medical, dental, and other health care records from each health care practitioner who provides care to an injured employee.

(15) "Mental health emergency" means a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

(16) "Network" or "workers' compensation health care network" means an organization that is:

(A) formed as a health care provider network to provide health care services to injured employees;

(B) certified in accordance with this chapter and commissioner rules; and

(C) established by, or operates under contract with, an insurance carrier.

(17) "Nurse" has the meaning assigned by Chapter 4201.

(18) "Person" means any natural or artificial person, including an individual, partnership, association, corporation, organization, trust, hospital district, community mental health center, mental retardation center, mental health and mental retardation center, limited liability company, or limited liability partnership.

(19) "Preauthorization" means the process required to request approval from the insurance carrier or the network to provide a specific treatment or service before the treatment or service is provided.

(20) "Quality improvement program" means a system designed to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions.

(21) Repealed by Acts 2009, 81st Leg., R.S., Ch. 1330, Sec. 19(1), eff. September 1, 2009.

(22) "Rural area" means:

(A) a county with a population of 50,000 or less;

(B) an area that is not designated as an urbanized area by the United States Census Bureau; or

(C) any other area designated as rural under

rules adopted by the commissioner.

(23) "Screening criteria" means the written policies, medical protocols, and treatment guidelines used by an insurance carrier or a network as part of utilization review.

(24) "Service area" means a geographic area within which health care services from network providers are available and accessible to employees who live within that geographic area.

(25) "Texas Workers' Compensation Act" means Subtitle A, Title 5, Labor Code.

(26) "Transfer of risk" means, for purposes of this chapter only, an insurance carrier's transfer of financial risk for the provision of health care services to a network through capitation or other means.

(27) "Utilization review" has the meaning assigned by Chapter 4201.

(28) "Utilization review agent" has the meaning assigned by Chapter 4201.

(29) "Utilization review plan" means the screening criteria and utilization review procedures of an insurance carrier, a workers' compensation health care network, or a utilization review agent.

(b) In this chapter, the following terms have the meanings assigned by Section 401.011, Labor Code:

- (1) "compensable injury";
- (2) "doctor";
- (3) "employer";
- (4) "health care";
- (5) "health care facility";
- (6) "health care practitioner";
- (7) "health care provider";
- (8) "injury";
- (9) "insurance carrier";
- (10) "orthotic device";
- (11) "prosthetic device"; and
- (12) "treating doctor."

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 134 (H.B. 1006), Sec. 4, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 147 (S.B. 458), Sec. 2, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.007, eff. April 1, 2009.

Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 2.01, eff. September 1, 2007.

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 1, eff. September 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 19(1), eff. September 1, 2009.

Sec. 1305.005. PARTICIPATION IN NETWORK; NOTICE OF NETWORK REQUIREMENTS. (a) An employer that elects to provide workers' compensation insurance coverage under the Texas Workers' Compensation Act may receive workers' compensation health care services for the employer's injured employees through a workers' compensation health care network.

(b) An insurance carrier may establish or contract with networks certified under this chapter to provide health care services under the Texas Workers' Compensation Act. If an employer elects to contract with an insurance company for the provision of health care services through a network, or if a self-insured employer under Chapter 407, Labor Code, a group of employers certified to self-insure under Chapter 407A, Labor Code, or a public employer under Subtitle C, Title 5, Labor Code, elects to establish or contract with a network, the employer's employees who live within the network's service area are required to obtain medical treatment for a compensable injury within the network, except as provided by Sections 1305.006(1) and (3).

(c) Notwithstanding Subsection (b), the State Office of Risk Management shall have exclusive authority to establish or contract with networks certified under this chapter to provide health care services under Chapter 501, Labor Code.

(d) The insurance carrier shall provide to the employer, and

the employer shall provide to the employer's employees, notice of network requirements, including all information required by Section 1305.451. The employer shall:

(1) obtain a signed acknowledgment from each employee, written in English, Spanish, and any other language common to the employer's employees, that the employee has received information concerning the network and the network's requirements; and

(2) post notice of the network requirements at each place of employment.

(e) The employer shall provide to each employee hired after the notice is given under Subsection (d) the notice and information required under that subsection not later than the third day after the date of hire.

(f) An injured employee who has received notice of network requirements but refuses to sign the acknowledgment form required under Subsection (d) remains subject to the network requirements established under this chapter.

(g) The employer shall notify an injured employee of the network requirements at the time the employer receives actual or constructive notice of an injury.

(h) An injured employee is not required to comply with the network requirements until the employee receives the notice under Subsection (d), (e), or (g). An insurance carrier that establishes or contracts with a network is liable for the payment of medical care under the requirements of Title 5, Labor Code, for an injured employee who does not receive notice until the employee receives notice of network requirements under this section.

(i) The commissioner may adopt rules as necessary to implement this section.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.006. INSURANCE CARRIER LIABILITY FOR OUT-OF-NETWORK HEALTH CARE. An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee:

(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; and

(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 pursuant to Section 1305.103. Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.007. RULES. The commissioner may adopt rules as necessary to implement this chapter. Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.008. ADMINISTRATOR CERTIFICATE OF AUTHORITY REQUIRED. A person that performs the functions of an administrator under Chapter 4151 must hold a certificate of authority issued under that chapter to provide those functions under this chapter for an insurance carrier. Added by Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 2.02, eff. September 1, 2007.

SUBCHAPTER B. CERTIFICATION

Sec. 1305.051. CERTIFICATION REQUIRED. (a) A person may not operate a workers' compensation health care network in this state unless the person holds a certificate issued under this chapter and rules adopted by the commissioner.

(b) A person may not perform any act of a workers' compensation health care network except in accordance with the specific authorization of this chapter or rules adopted by the commissioner.

(c) A health maintenance organization regulated under Chapter 843 or an organization of physicians and providers that operates as a preferred provider benefit plan, as defined by Chapter 1301, may obtain a certification as a workers' compensation

health care network in the same manner as any other person if that entity meets the requirements of this chapter and rules adopted by the commissioner under this chapter.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.052. CERTIFICATE APPLICATION. (a) A person who seeks to operate as a workers' compensation health care network shall apply to the department for a certificate to organize and operate as a network.

(b) A certificate application must be:

(1) filed with the department in the form prescribed by the commissioner;

(2) verified by the applicant or an officer or other authorized representative of the applicant; and

(3) accompanied by a nonrefundable fee set by commissioner rule.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.053. 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) biographical information regarding each person who governs or manages the affairs of the applicant, accompanied by information sufficient to allow the commissioner to determine the competence, fitness, and reputation of each officer or director of the applicant or other person having control of the applicant;

(3) a copy of the form of any contract between the applicant and any provider or group of providers, and with any third party performing services on behalf of the applicant under

Subchapter D;

(4) a copy of the form of each contract with an insurance carrier, as described by Section 1305.154;

(5) a financial statement, current as of the date of the application, that is prepared using generally accepted accounting practices and includes:

(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;

(6) 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 Chapter 804 for a domestic company;

(7) a description and a map of the applicant's service area or areas, with key and scale, that identifies each county or part of a county to be served;

(8) a description of programs and procedures to be utilized, including:

(A) a complaint system, as required under Subchapter I;

(B) a quality improvement program, as required under Subchapter G; and

(C) the utilization review program described in Subchapter H;

(9) a list of all contracted network providers that demonstrates the adequacy of the network to provide comprehensive health care services sufficient to serve the population of injured employees within the service area and maps that demonstrate that the access and availability standards under Subchapter G are met; and

(10) any other information that the commissioner requires by rule to implement this chapter.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 2, eff. September 1, 2009.

Sec. 1305.054. ACTION ON APPLICATION; RENEWAL OF CERTIFICATION. (a) The commissioner shall approve or disapprove an application for certification as a network not later than the 60th day after the date the completed application is received by the department. An application is considered complete on receipt of all information required by this chapter and any commissioner rules, including receipt of any additional information requested by the commissioner as needed to make the determination.

(b) Additional information requested by the commissioner under Subsection (a) may include information derived from an on-site quality-of-care examination.

(c) The department shall notify the applicant of any deficiencies in the application and may allow the applicant to request additional time to revise the application, in which case the 60-day period for approval or disapproval is tolled. The commissioner may grant or deny requests for additional time at the commissioner's discretion.

(d) An order issued by the commissioner disapproving an application must specify in what respects the application does not comply with applicable statutes and rules. An applicant whose application is disapproved may request a hearing not later than the 30th day after the date of the commissioner's disapproval order. The hearing is a contested case hearing under Chapter 2001, Government Code.

(e) A certificate issued under this subchapter is valid until revoked or suspended.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.055. USE OF CERTAIN INSURANCE TERMS BY NETWORK PROHIBITED. 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:

(1) descriptive of the insurance, casualty, or surety

business; or

(2) deceptively similar to the name or description of an insurer or surety corporation engaging in the business of insurance in this state.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.056. RESTRAINT OF TRADE; APPLICATION OF CERTAIN LAWS. (a) A network that contracts with a provider or providers practicing individually or as a group is not, because of the contract or arrangement, considered to have entered into a conspiracy in restraint of trade in violation of Chapter 15, Business & Commerce Code.

(b) Notwithstanding any other law, a person who contracts under this chapter with one or more providers in the process of conducting activities that are permitted by law but that do not require a certificate of authority or other authorization under this code is not, because of the contract, considered to have entered into a conspiracy in restraint of trade in violation of Chapter 15, Business & Commerce Code.

(c) A network is subject to Chapters 441 and 443 and is considered an insurer or insurance company, as applicable, for purposes of those laws.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.008, eff. April 1, 2009.

SUBCHAPTER C. GENERAL POWERS AND DUTIES OF WORKERS' COMPENSATION HEALTH CARE NETWORKS

Sec. 1305.101. PROVIDING OR ARRANGING FOR HEALTH CARE. (a) Except for emergencies and out-of-network referrals, a network shall provide or arrange for health care services only through providers or provider groups that are under contract with or are employed by the network.

(b) A network doctor may not serve as a designated doctor or perform a required medical examination, as those terms are used under the Texas Workers' Compensation Act, for an employee receiving medical care through a network with which the doctor contracts or is employed.

(c) Notwithstanding any other provision of this chapter, prescription medication or services, as defined by Section 401.011(19)(E), Labor Code, may not, directly or through a contract, be delivered through a workers' compensation health care network. Prescription medication and services shall be reimbursed as provided by Section 408.0281, Labor Code, other provisions of the Texas Workers' Compensation Act, and applicable rules of the commissioner of workers' compensation.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 705 (H.B. 528), Sec. 4, eff. June 17, 2011.

Sec. 1305.102. MANAGEMENT CONTRACTS. (a) A network may not enter into a contract with another entity for management services unless the proposed contract is first filed with the department and approved by the commissioner.

(b) The commissioner shall approve or disapprove the contract not later than the 30th day after the date the contract is filed, or within a reasonable extended period that the commissioner specifies by notice given within the 30-day period.

(c) The contract must state that:

(1) the contract may not be canceled without cause without at least 90 days' prior written notice;

(2) notice of any cancellation must be sent simultaneously to the commissioner by certified mail; and

(3) the network is responsible for ensuring that all functions delegated by the contract are performed in accordance with applicable statutes and rules, subject to the carrier's oversight and monitoring of the network's performance.

(d) The management contractor proposing to contract shall

provide to the commissioner information sufficient to allow the commissioner to determine the competence, fitness, or reputation of each of the contractor's officers and directors or other person having control of the contractor, including criminal history information demonstrating that none of those individuals has been convicted of a felony involving moral turpitude or breach of fiduciary duty.

(e) The commissioner shall disapprove the proposed contract if the commissioner determines that the contract authorizes a person who is not sufficiently trustworthy, competent, experienced, and free from conflict of interest to manage the network with due regard for the interests of employers, employees, creditors, or the public.

(f) The commissioner may not approve a proposed management contract unless the management contractor has in force in the management contractor's own name a fidelity bond on the contractor's officers and employees in the amount of \$250,000 or a greater amount prescribed by the commissioner.

(g) The fidelity bond must be issued by an insurer authorized to engage in business in this state and must be filed with the department. If the commissioner determines that a fidelity bond is not available from an insurer authorized to engage in business in this state, the management contractor may obtain a fidelity bond procured by a surplus lines agent under Chapter 981.

(h) The fidelity bond must obligate the surety to pay any loss of money or other property or damage that the network sustains because of an act of fraud or dishonesty by an employee or officer of the management contractor during the period that the management contract is in effect.

(i) In lieu of a fidelity bond, and at the commissioner's discretion, the management contractor may deposit with the comptroller cash or readily marketable liquid securities acceptable to the commissioner. The deposit must be maintained in the amount of, and is subject to the same conditions required for, a fidelity bond under this section.

(j) A management contract approved by the commissioner under this section may not be assigned to any other entity.

(k) A management contract filed with the department under this section is confidential and is not subject to disclosure as public information under Chapter 552, Government Code. Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.103. TREATING DOCTOR; REFERRALS. (a) A network shall determine the specialty or specialties of doctors who may serve as treating doctors.

(b) For each injury, an injured employee shall select a treating doctor from the list of all treating doctors under contract with the network in that service area.

(c) An employee who lives within the service area of a network and who is being treated by a non-network provider for an injury that occurred before the employer's insurance carrier established or contracted with the network, shall select a network treating doctor on notification by the carrier that health care services are being provided through the network. The carrier shall provide to the employee all information required by Section 1305.451. If the employee fails to select a treating doctor on or before the 14th day after the date of receipt of the information required by Section 1305.451, the network may assign the employee a network treating doctor. An issue regarding whether a carrier properly provided an employee the information required by this subsection may be resolved using the process for adjudication of disputes under Chapter 410, Labor Code, as used by the department's division of workers' compensation.

(d) Each network shall, by contract, require treating doctors to provide, at a minimum, the functions and services for injured employees described by this section.

(e) A treating doctor shall provide health care to the employee for the employee's compensable injury and shall make referrals to other network providers, or request referrals to out-of-network providers if medically necessary services are not available within the network. Referrals to out-of-network providers must be approved by the network. The network shall approve a referral to an out-of-network provider not later than the

seventh day after the date on which the referral is requested, or sooner if circumstances and the condition of the employee require expedited approval. If the network denies the referral request, the employee may appeal the decision through the network's complaint process under Subchapter I.

(f) The treating doctor shall participate in the medical case management process as required by the network, including participation in return-to-work planning.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1066 (S.B. 809), Sec. 4, eff. September 1, 2011.

Sec. 1305.104. SELECTION OF TREATING DOCTOR. (a) An injured employee 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. The following does not constitute an initial choice of treating doctor:

- (1) a doctor salaried by the employer;
- (2) a doctor providing emergency care; or
- (3) any doctor who provides care before the employee is enrolled in the network, except for a doctor selected under Section 1305.105.

(b) An employee who is dissatisfied with the initial choice of a treating doctor is entitled to select an alternate treating doctor from the network's list of treating doctors who provide services within the service area in which the injured employee lives by notifying the network in the manner prescribed by the network. The network may not deny a selection of an alternate treating doctor.

(c) An employee who is dissatisfied with an alternate treating doctor must obtain authorization from the network to select any subsequent treating doctor. The network shall establish procedures and criteria to be used in authorizing an

employee to select subsequent treating doctors. The criteria must include, at a minimum, whether:

(1) treatment by the current treating doctor is medically inappropriate;

(2) the employee is receiving appropriate medical care to reach maximum medical improvement or medical care in compliance with the network's treatment guidelines; and

(3) a conflict exists between the employee and the current treating doctor to the extent that the doctor-patient relationship is jeopardized or impaired.

(d) Denial of a request for any subsequent treating doctor is subject to the appeal process for a complaint filed under Subchapter I.

(e) For purposes of this section, the following do not constitute the selection of an alternate or any subsequent treating doctor:

(1) a referral made by the treating doctor, including a referral for a second or subsequent opinion;

(2) the selection of a treating doctor because the original treating doctor:

(A) dies;

(B) retires; or

(C) leaves the network; or

(3) a change of treating doctor required because of a change of address by the employee to a location outside the service area distance requirements, as described by Section [1305.302\(g\)](#).

(f) A network shall provide that 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 nonprimary care physician specialist that is in the network as the injured employee's treating doctor.

(g) An application under Subsection (f) must:

(1) include information specified by the network, including certification of the medical need provided by the nonprimary care physician specialist; and

(2) be signed by the injured employee and the nonprimary care physician specialist interested in serving as the

injured employee's treating doctor.

(h) To be eligible to serve as the injured employee's treating doctor, a physician specialist must agree to accept the responsibility to coordinate all of the injured employee's health care needs.

(i) If a network denies a request under Subsection (f), the injured employee may appeal the decision through the network's established complaint resolution process under Subchapter I.
Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.105. TREATMENT BY A PRIMARY CARE PHYSICIAN OR PROVIDER UNDER CHAPTER 843; RECOMMENDATIONS REGARDING USE OF PREFERRED PROVIDER PLAN. (a) Notwithstanding any other provision of this chapter, 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.

(b) A doctor serving as an employee's treating doctor under Subsection (a) must agree to abide by the terms of the network's contract and comply with the provisions of this subchapter and Subchapters D and G. Services provided by such a doctor are considered to be network services and are subject to Subchapters H and I.

(c) Any change of doctor requested by an employee being treated by a doctor under Subsection (a) must be to a network doctor and is subject to the requirements of this chapter.

(d) In studying the adequacy of networks under this chapter, the department shall offer recommendations to the 80th Legislature regarding whether to make statutory changes to allow treatment by non-network providers through a preferred provider benefit plan, as defined by Chapter 1301.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.106. PAYMENT OF HEALTH CARE PROVIDER. Notwithstanding any other provision of this chapter, an insurance carrier shall pay, reduce, deny, or determine to audit, a claim for services provided through a workers' compensation health care network only in accordance with Section 408.027, Labor Code. Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.107. TELEPHONE ACCESS. (a) Each network shall have appropriate personnel reasonably available through a toll-free telephone service at least 40 hours per week during normal business hours, in both time zones in this state if applicable, to discuss an employee's care and to allow response to requests for information, including information regarding adverse determinations.

(b) A network must have a telephone system capable of accepting or recording or providing instructions to incoming calls during other than normal business hours. The network shall respond to those calls not later than two business days after the date:

- (1) the call was received by the network; or
- (2) the details necessary to respond were received by the network from the caller.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

SUBCHAPTER D. CONTRACTING PROVISIONS

Sec. 1305.151. TRANSFER OF RISK. A contract under this subchapter may not involve a transfer of risk.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.152. NETWORK CONTRACTS WITH PROVIDERS. (a) A network shall enter into a written contract with each provider or group of providers that participates in the network. A provider contract under this section is confidential and is not subject to disclosure as public information under Chapter 552, Government

Code.

(b) A network is not required to accept an application for participation in the network from a health care provider who otherwise meets the requirements specified in this chapter for participation if the network determines that the network has contracted with a sufficient number of qualified health care providers.

(c) Provider contracts and subcontracts must include, at a minimum, the following provisions:

(1) a hold-harmless clause stating that the network and the network's contracted providers are prohibited from billing or attempting to collect any amounts from employees for health care services under any circumstances, including the insolvency of the insurance carrier or the network, except as provided by Section [1305.451\(b\)\(6\)](#);

(2) a statement that the provider agrees to follow treatment guidelines adopted by the network under Section [1305.304](#), as applicable to an employee's injury;

(3) a continuity of treatment clause that states that if a provider leaves the network, 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;

(4) a clause regarding appeal by the provider of termination of provider status and applicable written notification to employees regarding such a termination, including provisions determined by the commissioner; and

(5) any other provisions required by the commissioner by rule.

(d) Continued care as described by Subsection (c)(3) must be requested by a provider. A dispute involving continuity of care is subject to the dispute resolution process under Subchapter I.

(e) 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.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.153. PROVIDER REIMBURSEMENT. (a) The amount of reimbursement for services provided by a network provider is determined by the contract between the network and the provider or group of providers.

(b) If an insurance carrier or network has preauthorized a health care service, the insurance carrier or network or the network's agent or other representative may not deny payment to a provider except for reasons other than medical necessity.

(c) Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation.

(d) Subject to Subsection (a), billing by, and reimbursement to, contracted and out-of-network providers is subject to the requirements of the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation, as consistent with this chapter. This subsection may not be construed to require application of rules of the commissioner of workers' compensation regarding reimbursement if application of those rules would negate reimbursement amounts negotiated by the network.

(e) An insurance carrier shall notify in writing a network provider if the carrier contests the compensability of the injury for which the provider provides health care services. A carrier may not deny payment for health care services provided by a network provider before that notification on the grounds that the injury was not compensable. Payment for medically necessary health care services provided prior to written notification of a compensability denial is not subject to denial, recoupment, or refund from a network provider based on compensability. If the insurance carrier successfully contests compensability, the carrier is liable for health care provided before issuance of the notification required by this subsection, up to a maximum of \$7,000.

(f) If, for the purposes of credentialing and contracting

with health care providers on behalf of the certified network, a person is serving as both a management contractor under Section [1305.102](#) 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 specify:

(1) the certified network's contract rate for health care services; and

(2) the amount of reimbursement the health care provider will be paid after the health care provider agent's fee for providing administrative services is applied.

(g) If a management contractor or third party to which the network delegates a function is serving as an agent for health care providers in the certified network, the management contractor or third party must disclose that relationship in its contract with the certified network.

(h) A contract described by Subsection (f), or a contract between a management contractor or third party to which the network delegates a function and a certified network, must comply with the requirements of this chapter.

(i) If a contract described by Subsection (f) complies with the requirements of this chapter, the health care provider shall be reimbursed in accordance with the terms of the contract. If a contract described by Subsection (f) does not comply with the requirements of this chapter, the health care provider shall be reimbursed in accordance with the certified network's contracted rate.

(j) A certified network, management contractor, or third party to which the network delegates a function may not require a health care provider, as a condition for contracting with the certified network, to utilize as a health care provider agent the management contractor or the third party.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. [7](#)), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 374 (H.B. [3152](#)), Sec. 1, eff. September 1, 2013.

Sec. 1305.154. NETWORK-CARRIER CONTRACTS. (a) Except for emergencies and out-of-network referrals, a network may provide health care services to employees only through a written contract with an insurance carrier. A network-carrier contract under this section is confidential and is not subject to disclosure as public information under Chapter 552, Government Code.

(b) A carrier and a network may negotiate the functions to be provided by the network, except that the network shall contract with providers for the provision of health care, and shall perform functions related to the operation of a quality improvement program and credentialing in accordance with the requirements of this chapter.

(c) A network's contract with a carrier must include:

(1) a description of the functions that the carrier delegates to the network, consistent with the requirements of Subsection (b), and the reporting requirements for each function;

(2) a statement that the network and any management contractor or third party to which the network delegates a function will perform all delegated functions in full compliance with all requirements of this chapter, the Texas Workers' Compensation Act, and rules of the commissioner or the commissioner of workers' compensation;

(3) a provision that the contract:

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

(B) must be terminated immediately if cause exists;

(4) a hold-harmless provision stating that the network, a management contractor, a third party to which the network delegates a function, and the network's contracted providers are prohibited from billing or attempting to collect any amounts from employees for health care services under any circumstances, including the insolvency of the carrier or the network, except as provided by Section 1305.451(b)(6);

(5) a statement that the carrier retains ultimate responsibility for ensuring that all delegated functions and all

management contractor functions are performed in accordance with applicable statutes and rules and that the contract may not be construed to limit in any way the carrier's responsibility, including financial responsibility, to comply with all statutory and regulatory requirements;

(6) a statement that the network's role is to provide the services described under Subsection (b) as well as any other services or functions delegated by the carrier, 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, at least monthly and in a form usable for audit purposes, the data necessary for the carrier to comply with reporting requirements of the department and the division of workers' compensation with respect to any services provided under the contract, as determined by commissioner rules;

(8) a requirement that the carrier, the network, any management contractor, and any third party to which the network delegates a function comply with the data reporting requirements of the Texas Workers' Compensation Act and rules of the commissioner of workers' compensation;

(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) payments to providers and notification to employees;

(B) quality of care;

(C) utilization review; and

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

(10) a provision that requires that any agreement by which the network delegates any function to a management contractor or any third party be in writing, and that such an agreement require the delegated third party or management contractor to be subject to all the requirements of this subchapter;

(11) 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 this code or another insurance law of this state;

(12) an acknowledgment that:

(A) any management contractor or third party to whom the network delegates a function must perform in compliance 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 the third party fails to meet monitoring standards established to ensure that functions delegated to the management contractor or the third party under the delegation contract are in full compliance with all statutory and regulatory requirements, the carrier or the network may cancel the delegation of one or more 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 information to employees as required by Section 1305.451; and

(14) a provision that requires the network, in contracting with a third party directly or through another third party, to require the third party to permit the commissioner to examine at any time any information the commissioner believes is relevant to the third party's financial condition or the ability of the network to meet the network's responsibilities in connection with any function the third party performs or has been delegated.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 134 (H.B. 1006), Sec. 5, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.009, eff. April 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 3, eff.

September 1, 2009.

Sec. 1305.1545. RESTRICTIONS ON PAYMENT AND REIMBURSEMENT.

(a) An insurance carrier or administrator may not reimburse a doctor or other health care provider, an institutional provider, or an organization of doctors and health care providers on a discounted fee basis for services that are provided to an injured employee unless:

(1) the carrier or administrator has contracted with either:

(A) the doctor or other health care provider, institutional provider, or organization of doctors and health care providers; or

(B) a network that has contracted with the doctor or other health care provider, institutional provider, or organization of doctors and health care providers; and

(2) the doctor or other health care provider, institutional provider, or organization of doctors and health care providers has agreed to the contract and has agreed to provide health care services under the terms of the contract.

(b) A party to a carrier-network contract may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the contract without the express authority of and prior adequate notification to the other contracting parties. This subsection does not affect the authority of the commissioner under this code to request and obtain information.

(c) An insurance carrier or administrator who violates this section:

(1) commits an unfair claim settlement practice in violation of Subchapter A, Chapter 542, Insurance Code; and

(2) is subject to administrative penalties under Chapters 82 and 84, Insurance Code.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1176 (H.B. 472), Sec. 2.03, eff. September 1, 2007.

Sec. 1305.155. COMPLIANCE REQUIREMENTS. (a) An insurance carrier that becomes aware of any information that indicates that the network, any management contractor, or any third party to which the network delegates a function is not operating in accordance with the contract or is operating in a condition that renders the continuance of the network's business hazardous to employees shall:

(1) notify the network in writing of those findings;

(2) request in writing a written explanation, with documentation supporting the explanation, of:

(A) the network's apparent noncompliance with the contract; or

(B) the existence of the condition that apparently renders the continuance of the network's business hazardous to employees; and

(3) notify the commissioner and provide the department with copies of all notices and requests submitted to the network and the responses and other documentation the carrier generates or receives in response to the notices and requests.

(b) A network shall respond to a request from a carrier under Subsection (a) in writing not later than the 30th day after the date the request is received.

(c) The carrier shall cooperate with the network to correct any failure by the network to comply with any regulatory requirement of the department.

(d) On receipt of a notice under Subsection (a), or if a complaint is filed with the department, on receipt of that complaint, the commissioner or the commissioner's designated representative shall examine the matters contained in the notice or complaint as well as any other matter relating to the financial solvency of the network or the network's ability to meet its responsibilities in connection with any function performed by the network or delegated to the network by the carrier.

(e) Except as provided by this subsection, on completion of the examination, the department shall report to the network and the carrier the results of the examination and any action the department determines is necessary to ensure that the carrier meets

its responsibilities under this chapter, this code, and rules adopted by the commissioner, and that the network can meet the network's responsibilities in connection with any function delegated by the carrier or performed by the network, any management contractor, or any third party to which the network delegates a function. The department may not report to the carrier any information regarding fee schedules, prices, cost of care, or other information not relevant to the monitoring plan.

(f) The network and the carrier shall respond to the department's report and submit a corrective plan to the department not later than the 30th day after the date of receipt of the report.

(g) The commissioner may order a carrier to take any action the commissioner determines is necessary to ensure that the carrier can provide all health care services under the Texas Workers' Compensation Act, including:

(1) reassuming the functions performed by or delegated to the network, including claims payments for services previously provided to injured employees;

(2) temporarily or permanently ceasing coverage of employees through the network;

(3) complying with the contingency plan required by Section 1305.154(c)(9), including permitting an injured employee to select a treating doctor in the manner provided by Section 408.022, Labor Code; or

(4) terminating the carrier's contract with the network.

(h) The carrier retains ultimate responsibility for ensuring that all delegated functions and all management contractor functions are performed in accordance with applicable statutes and rules and nothing in this section may be construed to limit in any way the carrier's responsibility, including financial responsibility, to comply with all statutory and regulatory requirements.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

SUBCHAPTER E. FINANCIAL REQUIREMENTS

Sec. 1305.201. NETWORK FINANCIAL REQUIREMENTS. (a) Each network shall prepare financial statements in accordance with generally accepted accounting standards, which must include adequate provisions for liabilities, including incurred but not reported obligations relating to providing benefits or services.

(b) Each network shall file the financial statement under Subsection (a) with the department in the manner prescribed by commissioner rule.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

SUBCHAPTER F. EXAMINATIONS

Sec. 1305.251. EXAMINATION OF NETWORK. (a) As often as the commissioner considers necessary, the commissioner or the commissioner's designated representative may review the operations of a network to determine compliance with this chapter. The review may include on-site visits to the network's premises.

(b) During on-site visits, the network must make available to the department all records relating to the network's operations.

(c) A network shall pay a fee to the department, in an amount set by the commissioner and in accordance with rules adopted by the commissioner, for the expenses of an examination conducted under this section or Section 1305.252 that:

(1) are incurred by the commissioner or under the commissioner's authority; and

(2) are directly attributable to that examination, including the actual salaries and expenses of the examiners directly attributable to that examination, as determined under rules adopted by the commissioner.

(d) Fees collected under this section shall be deposited to the credit of the Texas Department of Insurance operating account.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 188 (S.B. 1253), Sec. 2, eff. September 1, 2007.

Sec. 1305.252. EXAMINATION OF PROVIDER OR THIRD PARTY. If requested by the commissioner or the commissioner's representative, each provider, provider group, or third party with which the network has contracted to provide health care services or any other services delegated to the network by an insurance carrier shall make available for examination by the department that portion of the books and records of the provider, provider group, or third party that is relevant to the relationship with the network of the provider, provider group, or third party.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

SUBCHAPTER G. PROVISION OF SERVICES BY NETWORK; QUALITY
IMPROVEMENT PROGRAM

Sec. 1305.301. NETWORK ORGANIZATION; SERVICE AREAS. (a) The chief executive officer, operations officer, or governing body of a network is responsible for:

(1) the development, approval, implementation, and enforcement of:

(A) administrative, operational, personnel, and patient care policies; and

(B) network procedures; and

(2) the development of any documents necessary for the operation of the network.

(b) Each network shall have a chief executive officer or operations officer who:

(1) is accountable for the day-to-day administration of the network; and

(2) shall ensure compliance with all applicable statutes and rules pertaining to the operation of the network.

(c) Each network shall have a medical director, who must be an occupational medicine specialist or employ or contract with an occupational medicine specialist, and who must be licensed to

practice medicine in the United States. The medical director shall:

(1) be available at all times to address complaints, clinical issues, and any quality improvement issues on behalf of the network;

(2) be actively involved in all quality improvement activities; and

(3) comply with the network's credentialing requirements.

(d) The network shall establish one or more service areas within this state. For each defined service area, the network must:

(1) demonstrate to the satisfaction of the department the ability to provide continuity, accessibility, availability, and quality of services;

(2) specify the counties and zip code areas, or any parts of a county or zip code area, included in the service area; and

(3) provide a complete provider directory to all policyholders who have selected a network in the service area.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.302. ACCESSIBILITY AND AVAILABILITY REQUIREMENTS. (a) All services specified by this section must be provided by a provider who holds an appropriate license, unless the provider is exempt from license requirements.

(b) The network shall ensure that the network's provider panel includes an adequate number of treating doctors and specialists, who must be available and accessible to employees 24 hours a day, seven days a week, within the network's service area. A network must include sufficient numbers and types of health care providers to ensure choice, access, and quality of care to injured employees. An adequate number of the treating doctors and specialists must have admitting privileges at one or more network hospitals located within the network's service area to ensure that any necessary hospital admissions are made.

(c) Hospital services must be available and accessible 24 hours a day, seven days a week, within the network's service area. The network shall provide for the necessary hospital services by contracting with general, special, and psychiatric hospitals.

(d) Physical and occupational therapy services and chiropractic services must be available and accessible within the network's service area.

(e) Emergency care must be available and accessible 24 hours a day, seven days a week, without restrictions as to where the services are rendered.

(f) Except for emergencies, a network shall arrange for services, including referrals to specialists, to be accessible to employees on a timely basis on request, but not later than the last day of the third week after the date of the request.

(g) Each network shall provide that network services are sufficiently accessible and available as necessary to ensure that the distance from any point in the network's service area to a point of service by a treating doctor or general hospital is not greater than 30 miles in nonrural areas and 60 miles in rural areas and 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 75 miles in nonrural areas and 75 miles in rural areas. For portions of the service area in which the network identifies noncompliance with this subsection, the network must file an access plan with the department in accordance with Subsection (h).

(h) The network shall submit an access plan, as required by commissioner rules, to 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 within the distance specified by Subsection (g) because:

- (1) providers are not located within that distance;
- (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 that distance.

(i) The network may make arrangements with providers outside the service area to enable employees to receive a skill or specialty not available within the network service area.

(j) The network may not be required to expand services outside the network's service area to accommodate employees who live outside the service area.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.303. QUALITY OF CARE REQUIREMENTS. (a) A network shall develop and maintain an ongoing quality improvement program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services and to pursue opportunities for improvement. The quality improvement program must include return-to-work and medical case management programs.

(b) The network's governing body is ultimately responsible for the quality improvement program. The governing body shall:

(1) appoint a quality improvement committee that includes network providers;

(2) approve the quality improvement program;

(3) approve an annual quality improvement plan;

(4) meet at least annually to receive and review reports of the quality improvement committee or group of committees, and take action as appropriate; and

(5) review the annual written report on the quality improvement program.

(c) The quality improvement committee or committees shall evaluate the overall effectiveness of the quality improvement program as determined by commissioner rules.

(d) The quality improvement program must be continuous and comprehensive and must address both the quality of clinical care and the quality of services. The network shall dedicate adequate resources, including adequate personnel and information systems, to the quality improvement program.

(e) The network shall develop a written description of the quality improvement program that outlines the organizational structure of the program, the functional responsibilities of the

program, and the frequency of committee meetings.

(f) The network shall develop an annual quality improvement work plan designed to reflect the type of services and the populations served by the network in terms of age groups, disease or injury categories, and special risk status, such as type of industry.

(g) The network shall prepare an annual written report to the department on the quality improvement program. The report must include:

- (1) completed activities;
- (2) the trending of clinical and service goals;
- (3) an analysis of program performance; and
- (4) conclusions regarding the effectiveness of the program.

(h) Each network shall implement a documented process for the selection and retention of contracted providers, in accordance with rules adopted by the commissioner.

(i) The quality improvement program must provide for a peer review action procedure for providers, as described by Section [151.002](#), Occupations Code.

(j) The network shall have a medical case management program with certified case managers. Case managers shall work with treating doctors, referral providers, and employers to facilitate cost-effective care and employee return-to-work.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.304. GUIDELINES AND PROTOCOLS. Each network shall adopt treatment guidelines, return-to-work guidelines, and individual treatment protocols. The treatment guidelines and individual treatment protocols must be evidence-based, scientifically valid, and outcome-focused and be designed to reduce inappropriate or unnecessary health care while safeguarding necessary care. Treatment may not be denied solely on the basis that the treatment for the compensable injury in question is not specifically addressed by the treatment guidelines used by the insurance carrier or network.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

SUBCHAPTER H. UTILIZATION REVIEW

Sec. 1305.351. UTILIZATION REVIEW IN NETWORK. (a) The requirements of Chapter 4201 apply to utilization review conducted in relation to claims in a workers' compensation health care network. In the event of a conflict between Chapter 4201 and this chapter, this chapter controls.

(b) Any screening criteria used for utilization review related to a workers' compensation health care network must be consistent with the network's treatment guidelines.

(c) The preauthorization requirements of Section 413.014, Labor Code, and commissioner of workers' compensation rules adopted under that section, do not apply to health care provided through a workers' compensation network. If a network or carrier uses a preauthorization process within a network, the requirements of this subchapter and commissioner rules apply. A network or an insurance carrier may not require preauthorization of treatments and services for a medical emergency.

(d) A utilization review agent or an insurance carrier that uses doctors to perform reviews of health care services provided under this chapter, including utilization review, or peer reviews under Section 408.0231(g), Labor Code, may only use doctors licensed to practice in this state.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 134 (H.B. 1006), Sec. 6, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 2G.010, eff. April 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 5, eff. September 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.11, eff. September 1, 2019.

Sec. 1305.353. NOTICE OF CERTAIN UTILIZATION REVIEW DETERMINATIONS; PREAUTHORIZATION REQUIREMENTS. (a) The entity performing utilization review shall notify the employee or the employee's representative, if any, and the requesting provider of a determination made in a utilization review.

(b) Notification of an adverse determination must include:

(1) the principal reasons for the adverse determination;

(2) the clinical basis for the adverse determination;

(3) a description of or the source of the screening criteria that were used as guidelines in making the determination;

(4) a description of the procedure for the reconsideration process; and

(5) notification of the availability of independent review in the form prescribed by the commissioner.

(c) On receipt of a preauthorization request from a provider for proposed services that require preauthorization, the utilization review agent shall issue and transmit a determination indicating whether the proposed health care services are preauthorized. The utilization review agent shall respond to requests for preauthorization within the periods prescribed by this section.

(d) For services not described under Subsection (e) or (f), the determination under Subsection (c) must be issued and transmitted not later than the third working day after the date the request is received. For the purposes of this subsection, "working day" has the meaning assigned by Section [4201.002](#).

(e) If the proposed services are for concurrent hospitalization care, the utilization review agent shall, within 24 hours of receipt of the request, transmit a determination indicating whether the proposed services are preauthorized.

(f) If the proposed health care services involve poststabilization treatment or a life-threatening condition, the utilization review agent shall transmit to the requesting provider a determination indicating whether the proposed services are preauthorized within the time appropriate to the circumstances

relating to the delivery of the services and the condition of the patient, not to exceed one hour from receipt of the request. If the utilization review agent issues an adverse determination in response to a request for poststabilization treatment or a request for treatment involving a life-threatening condition, the utilization review agent shall provide to the employee or the employee's representative, if any, and the employee's treating provider the notification required under Subsection (a).

(g) For life-threatening conditions, the notification of adverse determination must include notification of the availability of independent review in the form prescribed by the commissioner.

(h) Treatments and services for an emergency do not require preauthorization.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 972 (H.B. 3625), Sec. 1, eff. September 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 6, eff. September 1, 2009.

Sec. 1305.354. RECONSIDERATION OF ADVERSE DETERMINATION.

(a) A utilization review agent shall maintain and make available a written description of the reconsideration procedures involving an adverse determination. The reconsideration procedures must be reasonable and must include:

(1) a provision stating that reconsideration must be performed by a provider other than the provider who made the original adverse determination;

(2) a provision that an employee, a person acting on behalf of the employee, or the employee's requesting provider may, not later than the 30th day after the date of issuance of written notification of an adverse determination, request reconsideration of the adverse determination either orally or in writing;

(3) a provision that, not later than the fifth calendar day after the date of receipt of the request, the network

shall send to the requesting party a letter acknowledging the date of the receipt of the request that includes a reasonable list of documents the requesting party is required to submit;

(4) a provision that, after completion of the review of the request for reconsideration of the adverse determination, the utilization review agent shall issue a response letter to the employee or person acting on behalf of the employee, and the employee's requesting provider, that:

(A) explains the resolution of the reconsideration; and

(B) includes:

(i) a statement of the specific medical or clinical reasons for the resolution;

(ii) the medical or clinical basis for the decision;

(iii) the professional specialty of any provider consulted; and

(iv) notice of the requesting party's right to seek review of the denial by an independent review organization and the procedures for obtaining that review; and

(5) written notification to the requesting party of the determination of the request for reconsideration as soon as practicable, but not later than the 30th day after the date the utilization review agent received the request.

(b) In addition to the written request for reconsideration, the reconsideration procedures must include a method for expedited reconsideration procedures for denials of proposed health care services involving poststabilization treatment or life-threatening conditions, and for denials of continued stays for hospitalized employees. The procedures must include a review by a provider who has not previously reviewed the case and who is of the same or a similar specialty as a provider who typically manages the condition, procedure, or treatment under review. The period during which that reconsideration must be completed shall be based on the medical or clinical immediacy of the condition, procedure, or treatment, but may not exceed one calendar day from the date of receipt of all information necessary to complete the

reconsideration.

(c) Notwithstanding Subsection (a) or (b), an employee with a life-threatening condition is entitled to an immediate review by an independent review organization and is not required to comply with the procedures for a reconsideration of an adverse determination.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.355. INDEPENDENT REVIEW OF ADVERSE DETERMINATION.

(a) The utilization review agent shall:

(1) permit the employee or person acting on behalf of the employee and the employee's requesting provider whose reconsideration of an adverse determination is denied to seek review of that determination within the period prescribed by Subsection (b) by an independent review organization assigned in accordance with Chapter 4202 and commissioner rules; and

(2) provide to the appropriate independent review organization, not later than the third business day after the date the utilization review agent receives notification of the assignment of the request to an independent review organization:

(A) any medical records of the employee that are relevant to the review;

(B) any documents used by the utilization review agent in making the determination;

(C) the response letter described by Section 1305.354(a)(4);

(D) any documentation and written information submitted in support of the request for reconsideration; and

(E) a list of the providers who provided care to the employee and who may have medical records relevant to the review.

(b) A request for independent review under Subsection (a) must be timely filed by the requestor as follows:

(1) for a request for preauthorization or concurrent review by an independent review organization, not later than the 45th day after the date of denial of a reconsideration for health

care requiring preauthorization or concurrent review; or

(2) for a request for retrospective medical necessity review, not later than the 45th day after the denial of reconsideration.

(c) The insurance carrier shall pay for the independent review provided under this subchapter.

(d) The department shall assign the review request to an independent review organization. An independent review organization that uses doctors to perform reviews of health care services under this chapter may only use doctors licensed to practice in this state.

(e) A party to a medical dispute that remains unresolved after a review under this section is entitled to a hearing and judicial review of the decision in accordance with Section [1305.356](#). The division of workers' compensation and the department are not considered to be parties to the medical dispute.

(f) A determination of an independent review organization related to a request for preauthorization or concurrent review is binding during the pendency of a dispute and the carrier and network shall comply with the determination.

(g) If a contested case hearing or judicial review is not sought under Section [1305.356](#), the carrier and network shall comply with the independent review organization's determination.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. [7](#)), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 133 (H.B. [1003](#)), Sec. 3, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2G.011, eff. April 1, 2009.

Acts 2011, 82nd Leg., R.S., Ch. 1162 (H.B. [2605](#)), Sec. 2, eff. September 1, 2011.

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. [1742](#)), Sec. 3.12, eff. September 1, 2019.

Sec. 1305.356. CONTESTED CASE HEARING ON AND JUDICIAL REVIEW OF INDEPENDENT REVIEW. (a) A party to a medical dispute

that remains unresolved after a review under Section 1305.355 is entitled to a contested case hearing. A hearing under this subsection shall be conducted by the department's division of workers' compensation in the same manner as a hearing conducted under Section 413.0311, Labor Code.

(b) At a contested case hearing held under Subsection (a), the administrative law judge conducting the hearing shall consider evidence-based treatment guidelines adopted by the network under Section 1305.304.

(c) A party that has exhausted all administrative remedies under Subsection (a) and is aggrieved by a final decision of the department's division of workers' compensation may seek judicial review of the decision.

(d) Judicial review under Subsection (c) shall be conducted in the manner provided for judicial review of a contested case under Subchapter G, Chapter 2001, Government Code, and is governed by the substantial evidence rule.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1162 (H.B. 2605), Sec. 3, eff. September 1, 2011.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 839 (H.B. 2111), Sec. 1, eff. September 1, 2017.

SUBCHAPTER I. COMPLAINT RESOLUTION

Sec. 1305.401. COMPLAINT SYSTEM REQUIRED. (a) Each network shall implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint.

(b) The network may require a complainant to file the complaint not later than the 90th day after the date of the event or occurrence that is the basis for the complaint.

(c) The complaint system must include a process for the notice and appeal of a complaint.

(d) The commissioner may adopt rules as necessary to implement this section.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.402. COMPLAINT INITIATION AND INITIAL RESPONSE; DEADLINES FOR RESPONSE AND RESOLUTION. (a) If a complainant notifies a network of a complaint, the network, not later than the seventh calendar day after the date the network receives the complaint, shall respond to the complainant, acknowledging the date of receipt of the complaint and providing a description of the network's complaint procedures and deadlines.

(b) The network shall investigate and resolve a complaint not later than the 30th calendar day after the date the network receives the complaint.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.403. RECORD OF COMPLAINTS. (a) Each network shall maintain a complaint and appeal log regarding each complaint. The commissioner shall adopt rules designating the classification of network complaints under this section.

(b) Each network shall maintain a record of and documentation on each complaint, complaint proceeding, and action taken on the complaint until the third anniversary of the date the complaint was received.

(c) A complainant is entitled to a copy of the network's record regarding the complaint and any proceeding relating to that complaint.

(d) The department, during any investigation or examination of a network, may review documentation maintained under this subchapter, including original documentation, regarding a complaint and action taken on the complaint.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.404. RETALIATORY ACTION PROHIBITED. A network may not engage in any retaliatory action against an employer or employee because the employer or employee or a person acting on behalf of the employer or employee has filed a complaint against the network.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.405. POSTING OF INFORMATION ON COMPLAINT PROCESS REQUIRED. (a) A contract between a network and a provider must require the provider to post, in the provider's office, a notice to injured employees on the process for resolving complaints with the network.

(b) The notice required under Subsection (a) must include the department's toll-free telephone number for filing a complaint. Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

SUBCHAPTER J. EMPLOYEE INFORMATION AND RESPONSIBILITIES

Sec. 1305.451. EMPLOYEE INFORMATION; RESPONSIBILITIES OF EMPLOYEE. (a) An insurance carrier that establishes or contracts with a network shall provide to employers, and the employer shall provide to its employees, an accurate written description of the terms and conditions for obtaining health care within the network's service area.

(b) The written description required under Subsection (a) must be in English, Spanish, and any additional language common to an employer's employees, must be in plain language and in a readable and understandable format, and must include, in a clear, complete, and accurate format:

(1) a statement that the entity providing health care to employees is a 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 statement that in the event of an injury, the employee must select a treating doctor:

(A) from a list of all the network's treating doctors who have contracts with the network in that service area; or

(B) as described by Section 1305.105;

(4) a statement that, except for emergency services,

the employee shall obtain all health care and specialist referrals through the employee's treating doctor;

(5) 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, except as provided by Subdivision (6);

(6) a statement that if the employee obtains health care from non-network providers without network approval, except as provided by Section 1305.006, the insurance carrier may not be liable, and the employee may be liable, for payment for that health care;

(7) information about how to obtain emergency care services, including emergency care outside the service area, and after-hours care;

(8) a list of the health care services for which the insurance carrier or network requires preauthorization or concurrent review;

(9) an explanation regarding continuity of treatment in the event of the termination from the network of a treating doctor;

(10) a description of the network's complaint system, including a statement that the network is prohibited from retaliating against:

(A) an employee if the employee files a complaint against the network or appeals a decision of the network; or

(B) a provider if the provider, on behalf of an employee, reasonably files a complaint against the network or appeals a decision of the network;

(11) a summary of the insurance carrier's or network's procedures relating to adverse determinations and the availability of the independent review process;

(12) a list of network providers updated at least quarterly, including:

(A) the names and addresses of the providers;

(B) a statement of limitations of accessibility and referrals to specialists; and

(C) a disclosure of which providers are accepting

new patients; and

(13) a description of the network's service area.

(c) The network and the network's representatives and agents may not cause or knowingly permit the use or distribution to employees of information that is untrue or misleading.

(d) A network that contracts with an insurance carrier shall provide all the information necessary to allow the carrier to comply with this section.

(e) An issue regarding whether an employer properly provided an employee with the information required by this section may be resolved using the process for adjudication of disputes under Chapter 410, Labor Code, as used by the department's division of workers' compensation.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1066 (S.B. 809), Sec. 5, eff. September 1, 2011.

SUBCHAPTER K. EVALUATION OF NETWORKS; CONSUMER REPORT CARD

Sec. 1305.502. CONSUMER REPORT CARDS. (a) Not later than December 1 of each even-numbered year, the group shall develop and issue an informational report card that identifies and compares, on an objective basis, the quality, costs, health care provider availability, and other analogous factors of workers' compensation health care networks operating under the workers' compensation system of this state with each other and with medical care provided outside of networks.

(b) The group may procure services as necessary to produce the report card. The report card must include a risk-adjusted evaluation of:

- (1) employee access to care;
- (2) return-to-work outcomes;
- (3) health-related outcomes;
- (4) employee satisfaction with care; and
- (5) health care costs and utilization of health care.

(c) The report cards may be based on information or data from any person, agency, organization, or governmental entity that the group considers reliable. The group may not endorse or recommend a specific workers' compensation health care network or plan, or subjectively rate or rank networks or plans, other than through comparison and evaluation of objective criteria.

(d) The commissioner shall ensure that consumer report cards issued by the group under this section are accessible to the public on the department's Internet website and available to any person on request. The commissioner by rule may set a reasonable fee for obtaining a paper copy of report cards.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 670 (H.B. 1753), Sec. 1, eff. June 15, 2021.

Acts 2021, 87th Leg., R.S., Ch. 856 (S.B. 800), Sec. 21, eff. September 1, 2021.

Sec. 1305.503. CONFIDENTIALITY REQUIREMENTS. (a) As necessary to implement this subchapter, the department may access information from an executive agency that is otherwise confidential under any law of this state, including the Texas Workers' Compensation Act.

(b) Confidential information provided to or obtained by the department under this section remains confidential and is not subject to disclosure under Chapter 552, Government Code. The department may not release, and a person may not gain access to, any information that:

(1) could reasonably be expected to reveal the identity of an injured employee; or

(2) discloses provider discounts or differentials between payments and billed charges for individual providers or networks.

(c) Information that is in the possession of the department and that relates to an individual injured employee, and any compilation, report, or analysis produced from the information that

identifies an individual injured employee, are not:

(1) subject to discovery, subpoena, or other means of legal compulsion for release to any person; or

(2) admissible in any civil, administrative, or criminal proceeding.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

SUBCHAPTER L. DISCIPLINARY ACTIONS

Sec. 1305.551. DETERMINATION OF VIOLATION; NOTICE. (a) If the commissioner determines that a network, insurance carrier, or any other person or third party operating under this chapter, including a third party to which a network delegates a function, or any third party with which a network contracts for management services, is in violation of this chapter, rules adopted by the commissioner under this chapter, or applicable provisions of the Labor Code or rules adopted under that code, the commissioner or a designated representative may notify the network, insurance carrier, person, or third party of the alleged violation and may compel the production of any documents or other information as necessary to determine whether the violation occurred.

(b) The commissioner's designated representative may initiate the proceedings under this section.

(c) A proceeding under this section is a contested case under Chapter 2001, Government Code.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.

Sec. 1305.552. DISCIPLINARY ACTIONS. If under Section 1305.551 the commissioner determines that a network, insurance carrier, or other person or third party described under Section 1305.551 has violated or is violating this chapter, rules adopted by the commissioner under this chapter, or the Labor Code or rules adopted under that code, the commissioner may:

(1) suspend or revoke a certificate issued under this code;

- (2) impose sanctions under Chapter 82;
- (3) issue a cease and desist order under Chapter 83;
- (4) impose administrative penalties under Chapter 84;

or

- (5) take any combination of these actions.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 4.02, eff. September 1, 2005.