

**USA Worker's Injury Network
Texas Workers' Compensation Health Care Network**

PARTICIPATING PROVIDER MANUAL

The 79th Texas Legislature reformed the workers' compensation system in Texas by enacting House Bill 7 ("HB 7"), which was signed into law on June 1, 2005. 28 Texas Administrative Code (TAC) Part I, Chapter 10 and Texas Insurance Code (TIC) Title 8, Chapter 1305 are collectively referred to as the Workers' Compensation Health Care Network Act ("The Act"). To meet the requirements, USA Worker's Injury Network (USA WIN) has compiled this Provider Manual to assist Network Providers participating in USA WIN. This manual outlines the requirements of Participating Network Providers as they pertain to the rules and regulations. For more information you may visit the Texas Department of Insurance, Division of Workers Compensation at: <http://www.tdi.state.tx.us/wc/>.

USA WIN is a certified Worker's Compensation Health Care Network focused on the improvement of clinical outcomes to Texas injured workers. USA WIN's focus is to promote a successful and timely return-to-work program through the cooperation of employers, employees, Insurance Carriers and Participating Network Providers.

USA WIN's return-to-work focus means all treatment proposed and rendered is focused on preparing the injured worker to return to productivity as soon as medically feasible. Treatment plans require active involvement of the provider, injured worker, employer, adjuster and case manager from initiation of treatment through release-to-work and/or settlement. Treatment plans should be practical and implementable. Throughout the process, it should be emphasized to the injured worker that the intent of the treatment is to allow them to return to the workplace in some capacity. This may include modified duty for a period of time, as soon as medically able to do so. Clear communication of the treatment plan, including anticipated time frames to all involved parties, is vital to reaching the treatment goals.

DEFINITIONS

Doctor:

A doctor of medicine, osteopathic medicine, optometry, dentistry, podiatry, or chiropractic who is licensed and authorized to practice.

Health care facility:

A hospital, emergency clinic, outpatient clinic, or other facility providing health care.

Health care practitioner:

An individual who is licensed to provide or render health care or a non-licensed individual who provides or renders health care under the direction or supervision of a doctor.

Health care provider:

A health care facility or health care practitioner.

Treating Doctor:

The physician primarily responsible for the employee's health care for an injury.

Designated Doctor:

A physician or provider who has successfully completed TDI Workers' Compensation Division approved training and examination on the assignment of impairment ratings, medical causation, extent of injury, functional restoration, return to work, and other disability management topics and must be fully authorized to certify maximum medical improvement (MMI).

Specialist:

The Specialist provides care to the injured worker after referral from a Treating Doctor. An adequate number of Specialists must have admitting privileges at one or more network hospitals located within the USA WIN service area to ensure that any necessary hospital admissions are made. In some cases, the Specialist may be designated as the Treating Doctor upon approval by Insurance Carrier.

Network Provider:

A provider who is contracted with and in good standing in the USA Worker's Injury Network.

Case Management:

A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an injured worker's health care needs through communication and application of available resources to promote quality and cost-effective outcomes.

Utilization Review:

A system for prospective or concurrent review of the medical necessity and appropriateness of health care services being provided or proposed to be provided to an injured worker within the State of Texas.

Retrospective Review:

The process of reviewing the medical necessity and reasonableness of health care that has been provided to an injured worker.

TREATING DOCTORS

All health care services and referrals must be provided by a USA WIN Treating Doctor if the injured worker lives inside the service area (except for emergency services). A Treating Doctor is identified as the primary physician responsible for providing and managing the injured workers

care. An adequate number of Treating Doctors must have admitting privileges at one or more network hospitals located within USA WIN's service area to ensure necessary hospital admissions are made. Family Practice, Internal Medicine, Occupational Medicine and Emergency Medicine Physicians have been designated as Treating Doctors in USA WIN. The Act grants full direction to employers that choose to use a certified network for its injured workers. Employers who choose to implement a Certified Network will have control and direction and channeling of an injured worker's care for the entire life of the claim.

Selection of a Treating Doctor

The selection of a Treating Doctor is essential for coverage in the network. For each injury, the injured worker must select a Treating Doctor in the service area from a list of participating providers provided by USA WIN. If prior to the injury the injured worker had selected a HMO primary care physician, they may request that the provider be approved to treat them for their injury. The injured worker's primary care physician must agree to the terms of USA WIN's provider agreement and comply with guidelines, protocols and Texas Insurance Code, Title 8, Chapter 1305 relating to quality improvement and credentialing. The HMO primary care physician does not have to participate in the USA WIN in order to be an authorized Treating Doctor.

Non-Primary Care Treating Doctor

The injured worker may request that a USA WIN Specialist serve as the Treating Doctor if they have a chronic, life-threatening injury, or a chronic pain related to a workers' compensation injury. In order for the Specialist to become the Treating Doctor, there must be medical need certified by the Specialist, and the Specialist must agree to accept the responsibility to coordinate the injured worker's health care needs. If Insurance Carrier denies the request, the injured worker may appeal through the internal complaint resolution process.

The request submitted to USA WIN must:

- Include information specified by USA WIN, including certification of the medical need provided by the non-primary care Specialist; and
- Be signed by the injured worker and the non-primary care Specialist interested in serving and the injured worker's Treating Doctor.

To be eligible to serve as the injured worker's Treating Doctor, a physician Specialist must agree to accept the responsibility to coordinate all of the injured worker's health care needs. If the request is denied, the injured employee may appeal the decision through USA WIN's established complaint resolution process.

Duties of Network Treating Doctor/Out-of-Network Referrals

1. A Treating Doctor must provide health care to the employee for the compensable injury and must participate in the Medical Case Management process as required by USA WIN, including participation in return-to-work planning.
2. A Treating Doctor must make referrals to other Participating Network Providers or request referrals to out-of-network providers if medically necessary services are not available within USA WIN.
3. Referrals to out-of-network providers require approval from USA WIN.

4. USA WIN must approve a referral to an out-of-network Participating Network Provider not later than the 7th day after the date on which the referral is requested, or sooner if circumstances and the condition of the employee required expedited approval.
5. Participating Network Providers are subject to the following requirements:
 - The Treating Doctor is responsible for the efficient management of medical care in accordance with USA WIN's Insurance Carriers' utilization review program and statutory and regulatory requirements;
 - Any rules adopted by the Commissioner defining the role of the Treating Doctor and specifying outcome information to be collected by a Treating Doctor;
 - Rules adopted by the Commissioner establishing reasonable requirements for doctors and health care providers financially related to those doctors, regarding training, impairment rating testing, and disclosure of financial interests, and for monitoring those doctors and other health care providers;
 - If the doctor intends to provide certifications of maximum medical improvement or assign impairment ratings, comply with the impairment rating training and testing requirements established by rule.

Medical Exams

An injured worker is required to have a single medical examination performed to define the compensable injury on request of the Insurance Carrier. The employee's Treating Doctor must perform the medical examination. After the examination is performed, the Treating Doctor must submit a report to the Insurance Carrier detailing all injuries and diagnoses related to the compensable injury. Upon receipt of the report, the Insurance Carrier must determine if they will accept or reject the Treating Doctor's report. If the report is accepted, the Insurance Carrier cannot deny any medical care on the basis of compensability. If the report is rejected, the Insurance Carrier can require any medical treatment related to the injury be preauthorized.

For in-network medical care, the Insurance Carrier is required to notify a Participating Network Provider, in writing, if the Insurance Carrier is disputing the compensability of a claim. The Insurance Carrier is also prohibited from denying a medical bill for compensability for services that were provided prior to the Insurance Carrier's written notification to the Participating Network Provider.

Designated Doctors

A USA WIN Participating Network Provider may not serve as a Designated Doctor or perform a required medical examination (RME) for an injured employee receiving medical care by the USA WIN Participating Network Provider. Required medical examinations will be performed by a Designated Doctor that is not currently treating the injured employee.

CHANGING TREATING DOCTORS

Alternate Treating Doctor

If the injured worker is dissatisfied with their initial choice of a Treating Doctor, they are entitled to select an alternate Treating Doctor from the USA WIN list who provides services within the service area in which they live. The injured worker may only select an alternate doctor one time without authorization. If they are dissatisfied with the alternate Treating Doctor, they must obtain authorization from the Insurance Carrier to select any subsequent Treating Doctor. Denial of a request for any subsequent Treating Doctor is subject to the Insurance Carrier's appeal process.

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 dies, retires, or leaves the network; and
3. A change of Treating Doctor required because of a change of address by the employee to a location outside of the service area.

DOCTOR AND PRACTITIONER RIGHTS

As a USA WIN Participating Network Provider, you have the following doctors' and practitioner's right:

- The right to review information submitted that supports the credentialing application;
- The right to correct erroneous information;
- The right, upon request, to be informed of status of credentialing or re-credentialing; and
- The right to be notified of these rights.

Economic Profiling

USA WIN and Insurance Carrier will notify Network Provider or group of Network Providers before USA WIN or Insurance Carrier conducts economic profiling, including utilization management studies comparing Network Provider to other Providers, or other profiling of the Network Provider or group of Network Providers.

QUALITY AND CREDENTIALING

In addition to USA WIN quality programs, USA WIN may also review your compliance with requirements applicable to you as a provider of services within USA WIN. USA WIN reserves the right to remove your name as a Participating Network Provider based on noncompliance with these requirements or upon receiving evidence of quality issues that make you ineligible for participation.

All providers who participate in USA WIN must be credentialed in compliance with statutory and regulatory requirements.

All practitioners, including Treating Doctors, are responsible for maintaining all required licenses and certifications required by state and federal law and in accordance with the credentialing requirements of USA WIN. Any change in status must be reported to USA WIN in accordance with your provider agreement.

For providers making application to become a USA WIN Participating Network Provider, the initial credentialing, including application, verification of information, and site visits, if applicable, must be complete before the effective date of the initial contract with the doctor or practitioner.

USA WIN, or its designee, must perform a site visit to the office of each Treating Doctor as part of the initial credentialing process. For group practices, USA WIN may perform one visit for all doctors in the group. An additional site visit is not required when a new doctor joins the group. (Note: The TDI has made an exception to allow a one year grace period for completing site visits).

SERVICE AREAS

Accessibility to Health Care Services

USA WIN must include:

- An adequate number of doctors that is available and accessible to injured workers, 24 hours a day, seven days a week, within USA WIN's service area.
- Except for emergencies, health care services, including referrals to Specialist, should be made within the time appropriate to the circumstances and condition of the injured employee but not later than 21 days after the date of the request.
- Treating Doctors must have coverage 24 hours a day seven days a week. In some situations, such as if a Treating Doctor is on vacation the doctor may make arrangements for another Treating Doctor to substitute as necessary.
- Hospital services must be available and accessible 24 hours a day, seven days a week.
- Physical/Occupational therapy services and chiropractic services must be available and accessible within USA WIN's service area.
- Emergency care must be available and accessible 24 hours a day, seven days a week, without restrictions as to where the services are rendered.
- An adequate number of doctors who are qualified to provide maximum medical improvement and impairment rating service.

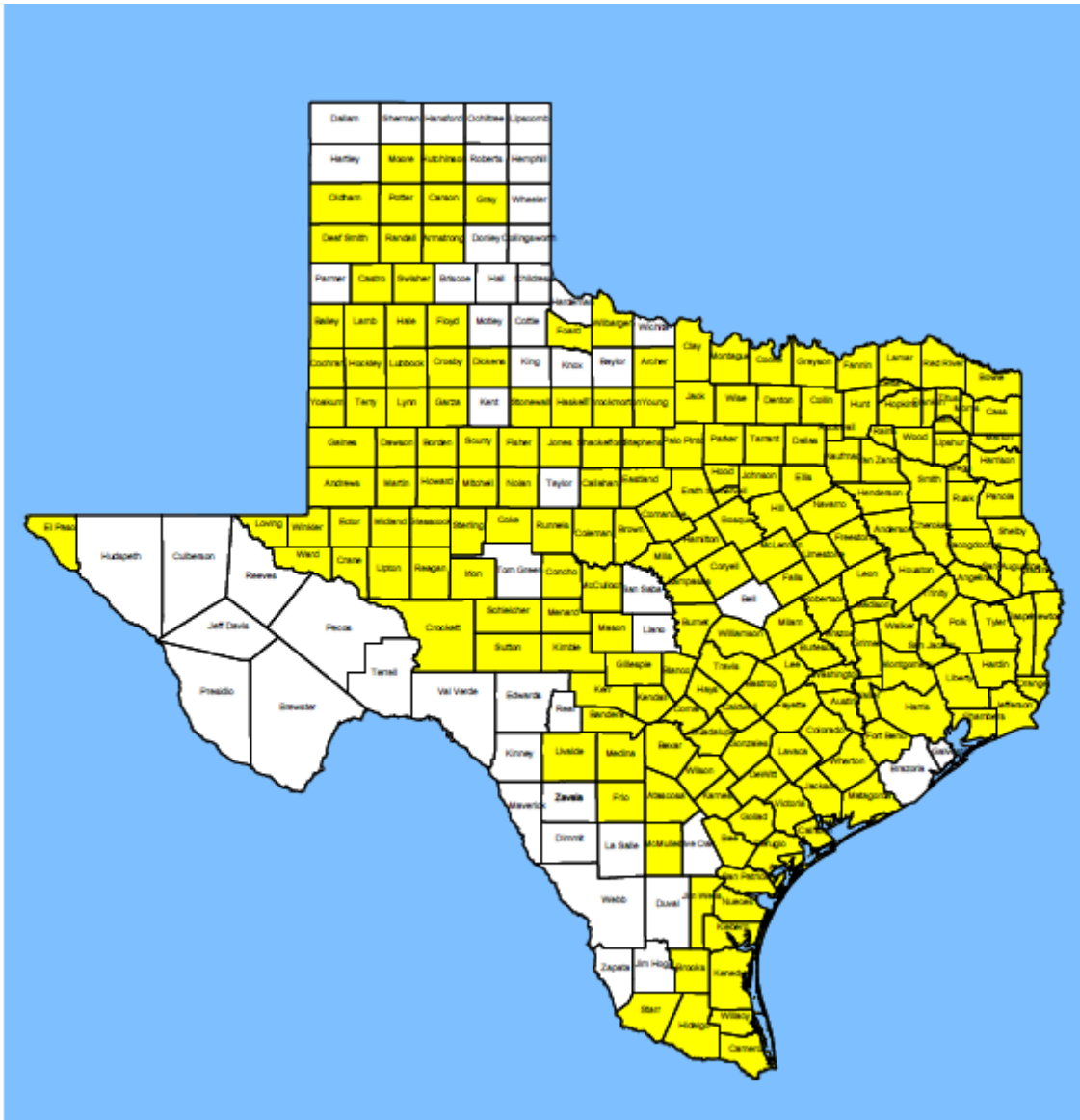
Service Area Description

Every certified Worker's Compensation Network must have one or more service areas where doctors and other health care workers are available to treat injured workers hurt on the job. For each defined service area, USA WIN must demonstrate to TDI the ability to provide continuity, accessibility, availability and quality of services. USA WIN is certified to provide services in the following geographic service areas:

Anderson	Dewitt	Johnson	Randall
Andrews	Dickens	Jones	Reagan
Angelina	Eastland	Karnes	Red River
Aransas	Ector	Kaufman	Refugio
Archer	El Paso	Kendall	Robertson
Armstrong	Ellis	Kenedy	Rockwall
Atascosa	Erath	Kerr	Runnels
Austin	Falls	Kimble	Rusk

Bailey	Fannin	Kleberg	Sabine
Bandera	Fayette	Lamar	San Augustine
Bastrop	Fisher	Lamb	San Jacinto
Bee	Floyd	Lampasas	San Patricio
Bexar	Foard	Lavaca	Schleicher
Blanco	Fort Bend	Lee	Scurry
Borden	Franklin	Leon	Shackelford
Bosque	Freestone	Liberty	Shelby
Bowie	Frio	Limestone	Smith
Brazos	Gaines	Loving	Somervell
Brooks	Garza	Lubbock	Starr
Brown	Gillespie	Lynn	Stephens
Burleson	Glasscock	Madison	Sterling
Burnet	Goliad	Marion	Stonewall
Caldwell	Gonzales	Martin	Sutton
Calhoun	Gray	Mason	Swisher
Callahan	Grayson	Matagorda	Tarrant
Cameron	Gregg	McCulloch	Terry
Camp	Grimes	McLennan	Throckmorton
Carson	Guadalupe	McMullen	Titus
Cass	Hale	Medina	Travis
Castro	Hamilton	Menard	Trinity
Chambers	Hardin	Midland	Tyler
Cherokee	Harris	Milam	Upshur
Clay	Harrison	Mills	Upton
Cochran	Haskell	Mitchell	Uvalde
Coke	Hays	Montague	Van Zandt
Coleman	Henderson	Montgomery	Victoria
Collin	Hidalgo	Moore	Walker
Colorado	Hill	Morris	Waller
Comal	Hockley	Nacogdoches	Ward
Comanche	Hood	Navarro	Washington
Concho	Hopkins	Newton	Wharton
Cooke	Houston	Nolan	Wilbarger
Coryell	Howard	Nueces	Willacy
Crane	Hunt	Oldham	Williamson
Crockett	Hutchinson	Orange	Wilson
Crosby	Irion	Palo Pinto	Winkler
Dallas	Jack	Panola	Wise
Dawson	Jackson	Parker	Wood
Deaf Smith	Jasper	Polk	Yoakum
Delta	Jefferson	Potter	Young
Denton	Jim Wells	Rains	

A map of the service area with the above counties can be viewed on USA WIN's website at www.usamco.com or below.



PROVIDER DIRECTORIES

The USA WIN Provider Directory is available in electronic format at www.usamco.com, or by e-mail upon request to USA WIN's Provider Network Administration department at 800-872-0820. Providers are grouped by county then specialty. Referrals to Specialists must be made through the Treating Doctors and/or be preauthorized by USA WIN.

In addition to the provider name, address and telephone number, the following information is clearly identified for each provider:

1. Providers who are authorized to assess maximum medical improvement and render impairment ratings;
2. Providers with any limitations of accessibility and referrals to Specialists; and

3. Providers who are accepting new patients.

USA WIN NETWORK SERVICES

If the injured worker lives inside the network service area, they must receive all medical treatment from a USA WIN Participating Network Provider unless indicated below in “Out-of-Network” services.

Out-of-Network

Injured workers are allowed to receive medical treatment out-of-network if they:

1. require emergency care;
2. do not live within the service area; or
3. are referred by the Treating Doctor to an out-of-network provider and that referral has been approved by USA WIN.

An Insurance Carrier is also liable for payment of out-of-network medical care for an injured worker if the employee has not received the ‘Employee Notice of Network Requirements’.

Emergency Care

An emergency is a medical or mental injury or the sudden onset of an illness that may endanger your life or cause permanent impairment.

- Medical emergency means the sudden onset of a medical condition manifested by acute symptoms of sufficient severity. This includes: severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patients’ health or bodily functions in serious jeopardy, or serious dysfunction of any body organ or part.
- 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.

After-Hours and Urgent Care

For non-emergency urgent health care or after hours, injured workers should go to the nearest USA WIN urgent care facility. USA WIN urgent care facilities are available to provide advice and treatment of urgent health problems 24 hours a day, 7 days a week, and 365 days a year. Urgent health problems (physical or emotional) include sudden, serious, and unexpected illnesses, injuries, or conditions which require immediate attention.

Referral to Out-of-Network Provider

A Treating Doctor may request referrals to out-of-network providers if medically necessary services are not available within USA WIN. Referrals to Out-of-Network providers must be approved by USA WIN. Such determination will be made within the time appropriate under the circumstances but not later than 7 days after the date the referral is requested. If USA WIN denies the referral request because the requested service is available from Participating Network Providers, the injured worker may file a complaint in accordance with the formal complaint process. If USA WIN denies

the request because the Specialist referral is not medically necessary, the injured worker may file a request for independent review.

USA WIN requires providers to see injured workers needing urgent care within 24 hours of the request. Non-urgent care appointments for initial treatment of an injury should be accommodated within 3 business days of the injured employee or Treating Doctor's request for treatment. Providers not able to meet these requirements should immediately notify USA WIN so that another Treating Doctor can be assigned. The same goes if a provider is unable to reasonably refer an injured worker for specialty care so that referral to another Specialist within USA WIN can take place.

Waiting time in a provider's office should not exceed reasonable community standards of more than 30-45 minutes. In addition, USA WIN Participating Network Providers should allow for sufficient time to meet with the injured worker. Initial exams should run 30-45 minutes for the initial exam and 15-30 minutes for follow-up visits.

BILLING/PAYMENT FOR SERVICE

Participating Network Provider Billing

USA WIN Participating Network Providers are required to bill the Insurance Carrier for all health care services provided to an injured worker. USA WIN Participating Network Providers will not bill the injured worker for any services related to an eligible and compensable injury, including the insolvency of the Insurance Carrier or USA WIN.

Out-of-Network Provider Billing

If the injured worker receives treatment from an out-of-network provider without prior approval by USA WIN, the injured worker may be responsible for the full payment of services received by the out-of-network provider.

The injured worker is NOT responsible for payment of treatment received by an out-of-network provider if:

- they receive a USA WIN approved referral from a USA WIN Treating Doctor;
- Due to emergency care; or
- If they live outside the USA WIN service area.

Prompt Submission and Payment of Medical Bills

The Insurance Carrier shall pay, deny or reduce medical bills no later than 45 days after the Insurance Carrier's receipt of the bill.

- USA WIN Participating Network Providers must submit a claim for payment to the Insurance Carrier not later than the 95th day after the date on which the health care services are provided to the injured worker. Failure to meet timely submission guidelines for the medical bill will result in forfeiture of the provider's right to reimbursement.
- The Insurance Carrier must pay, reduce, deny or determine to audit the provider's claim not later than the 45th day after the date of receipt by the Insurance Carrier of the provider's

claim. The Insurance Carrier may request additional documentation necessary to clarify the provider's charges at any time during the 45-day period.

- If the Insurance Carrier requests additional documentation with the 45 day period, the provider must provide the requested documentation no later than the 125th day after the date of receipt of the Insurance Carriers' request.
- If the Insurance Carrier chooses to audit the bill, the Insurance Carrier must pay 85% of the fee guideline amount or the contracted rate. Insurance Carriers must complete a bill audit no later than 160 days after the Insurance Carrier receives all documentation necessary for the bill. The Act also clarifies that these prompt payment timeframes will apply to both in- and out-of-network medical care.

Reimbursement to Insurance Carrier by USA WIN Participating Network Provider

If the services provided to an injured worker are determined by the Insurance Carrier to be inappropriate, the Insurance Carrier must notify the provider in writing of the Insurance Carrier's decision and demand a refund by the provider of the portion of the payment on the claim that was received by the provider for the inappropriate services. The provider may appeal the Insurance Carrier's determination by filing an appeal with the Insurance Carrier not later than the 45th day after the date of the Insurance Carrier's request for refund. The Insurance Carrier must act on the appeal not later than the 45th day after the date on which the provider files the appeal. The provider must reimburse the Insurance Carrier for payments received for inappropriate charges not later than the 45th day after the date of the Insurance Carrier's notice. Failure by the provider to timely remit payment constitutes an administrative violation.

COORDINATION OF TIMELY CARE

The Treating Doctor is responsible for rendering initial care to the injured worker and assessing whether further care may be necessary. The Treating Doctor must initiate clinical review as defined in the injured worker's instruction sheet that is presented at the time of the first visit. USA WIN Participating Network Providers are required to coordinate care, provide services, and be accessible to the injured worker on a timely basis. This includes initial evaluation, ongoing treatment, referrals to Specialists, responsiveness to inquiries or complaints, medical management, utilization review, and Case Management. Except for emergencies, the injured employees Treating Doctor will arrange for covered health care services, including referrals to Specialists, to be accessible to an employee on a timely basis upon request and within the time appropriate to the circumstances and condition, but not later than 21 days after the date of the request.

CONTINUITY OF CARE

USA WIN provides for continuity on care if the injured workers health could be jeopardized if medically necessary covered services are disrupted or interrupted. Insurance Carrier and/or USA WIN will assist with the coordination of any transition of care from an out-of-network provider to a

USA WIN Participating Network Provider or from a USA WIN Participating Network Provider who terminates within the network to an active USA WIN Participating Network Provider.

Should a Participating Network Provider terminate participation, USA WIN will require provider to treat an injured worker at the same contractual terms, conditions and rates that were imposed prior to the contract termination date for a period not to exceed 90 days if the care is for an injured worker with a life-threatening condition or an acute condition for which disruption of care would harm the employee.

CASE MANAGEMENT

USA WIN's Insurance Carriers must have a Medical Case Management program with Certified Case Managers. A claims adjuster may not serve as a Case Manager pursuant to Labor Code §413.021. Providers are expected to cooperate with Case Managers.

At the current time USA WIN utilizes the following evidence-based, scientifically valid and outcome-focused guidelines which are considered to be correct on the issue of extent and scope of medical treatment: Official Disability Guidelines (ODG) as treatment guidelines and Presley Reed Group Disability Guidelines, and Presley Reed/Medical Disability Advisor (MDA) as return-to-work guidelines.

USA WIN case managers will assist Treating Doctors in obtaining exposure data, job descriptions, availability of modified duty opportunities in a specific work setting used to formulate a return-to-work plan for the injured workers. USA WIN Participating Network Providers, including Treating Doctors, Specialists, and referral providers must work with case managers to facilitate cost-effective care and employee return-to-work.

The Insurance Carrier may not deny treatment solely on the basis that treatment for a compensable injury in question is not specifically addressed by the treatment guidelines used by the Insurance Carrier or USA WIN.

A dispute concerning continuity of care shall be resolved through USA WIN's complaint resolution process.

PRE-AUTHORIZATION

Pre-authorization determines whether medical services are medically necessary and provided in the appropriate setting or at the appropriate level of care. Pre-authorization requirements are a responsibility of the USA WIN Participating Network Provider not the employee.

Out-of-Network services always require pre-authorization. If no pre-authorization or referral is obtained for the out-of-network services, no benefits are available and out-of-network claims will be denied. Insurance Carrier will respond to request for pre-authorization within the periods described below:

- Within the 3rd working day for pre-authorization requests;
- 24 hours of receipt for a request for concurrent hospitalization care; and
- Within 1 hour for post-stabilization treatment or a life-threatening condition.

Note: Failure to meet pre-authorization requirements may result in non-payment. USA WIN Participating Network Providers cannot bill or collect fees from employees for services. This list may not be revised without prior notification to providers and employees per applicable law.

The following list represents the procedures that usually require preauthorization from USA WIN's INSURERS using USA Worker's Injury Network. This list is not intended to be comprehensive or all inclusive and may vary by INSURERS. USA WIN Network Providers should verify specific preauthorization requirements with INSURER prior to rendering healthcare services.

- All Hospitalizations
- All Surgeries
- All outpatient surgeries including: epidural steroid injections, facet injections, trigger point injections, sacroiliac joint injections, prolotherapy injections, radiological cryotherapy, and manipulations under anesthesia, and including the specific site or facility where the service will be performed
- Repeat diagnostic studies
- All Durable Medical Equipment
- Chemical Dependence, weight loss programs, and gym memberships
- All nursing home, convalescent, residential and all home health care services and treatments
- Psychological or Psychiatric testing, and evaluations
- All Bone Growth stimulators
- All chemonucleolysis, vertebral axial decompressions (Vax-D), radio frequency thermocoagulation of facet joints (RFTC), and IDET procedures
- All myelograms, discograms, venograms, surface electromyograms, EMGs, and nerve conduction studies
- Work Hardening and Work conditioning
- Rehabilitation Programs
- All Physical therapy, occupational therapy, chiropractic therapy, and chiropractic manipulations
- All out-of-network referrals
- Dental work over \$1000
- Psyche testing
- Request for long-term medications, especially narcotics
- Psychotherapy, with social worker, psychologist or psychiatrist
- Biofeedback and pain management, initial evaluation and 'full' chronic pain management programs

Pursuant to 28 TAC Chapter 134, Subchapter F, Rule §135.540 Preauthorization for claims subject to the Division's closed formulary. Preauthorization is only required for:

- (1) drugs identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*, and any updates;
 - (2) any compound that contains a drug identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary*, and any updates; and
 - (3) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).
- (c) Preauthorization of intrathecal drug delivery systems.

(1) An intrathecal drug delivery system requires preauthorization in accordance with the certified network's treatment guidelines and preauthorization requirements pursuant to Insurance Code Chapter 1305 and Chapter 10 of this title (relating to Workers' Compensation Health Care Networks).

(2) Refills of an intrathecal drug delivery system with drugs excluded from the closed formulary, which are billed using Healthcare Common Procedure Coding System (HCPCS) Level II J codes, and submitted on a CMS-1500 or UB-04 billing form, require preauthorization on an annual basis. Preauthorization for these refills is also required whenever:

(A) the medications, dosage or range of dosages, or the drug regime proposed by the prescribing doctor differs from the medications dosage or range of dosages, or drug regime previously preauthorized by that prescribing doctor; or

(B) there is a change prescribing doctor.

COMPLAINT AND APPEAL PROCEDURES

All complaints whether verbal or written must be received no later than the 90th day after the date of the event or occurrence that is the basis for the complaint. The Network can be contacted at:

USA Worker's Injury Network
Executive Director PNA
1250 S. Capital of Texas Highway, Bldg 3-500
Austin, Texas 78746
512-306-0201
Toll Free 800-872-0820
Fax 512-328-6785

E-Mail: medicalreviewcommittee@usamco.com

USA WIN will acknowledge receipt of the complaint by letter within 7 calendar days and send an acknowledgment letter that will include a description of the complaint procedures, time frames, and a one-page complaint form (**Attachment A**) for the appealing party to complete if the complaint is received verbally. At that time, a request will be made for any additional information that may be warranted to process the dispute.

After USA WIN has investigated a complaint, USA WIN will issue a resolution letter to the complainant no later than the 30th calendar day after receipt of the complaint.

If the complainant is dissatisfied with the resolution of the complaint or the process, the complainant may file a complaint with the Texas Department of Insurance according to the Complaints to Texas Insurance section below.

USA WIN shall not engage in any retaliatory action against an employee, employer, or provider because the employee, employer, provider, or any other person acting on behalf of the employer or employee has filed a complaint against USA WIN.

USA WIN Participating Network Providers are required to post, in their office, a notice to employees on the process for resolving complaints.

All complaints will be forwarded to the attention of the Executive Director of Provider Network Administration and will be documented within USA WIN's Complaint Resolution Log. All pertinent information including caller's name, number and nature of the grievance is recorded. A record and documentation of each complaint will be kept for a period of three years from the date the complaint was received.

Fee Disputes

The Act requires USA WIN to set up and maintain an internal complaint resolution process. Since fees for in-network medical care are subject to negotiation between the network and the provider, The Act requires all in-network fee disputes to be handled by the certified entity's internal complaint resolution process.

In order to minimize the number of disputes, by maximizing our ability to identify recurring issues, all claim discrepancies and provider billing and payment issues are handled exclusively by contacting USA WIN's Claims Liaison Department via e-mail at claimsliaison@usamco.com or by calling 800-872-0820. Claims Liaison will communicate with the applicable department to address consistent concerns. Monthly Claims Liaison Reports will be monitored by MRC.

ADVERSE DETERMINATIONS UTILIZATION REVIEW (DENIALS)

The statutory and regulatory requirements of the TIC pertaining to utilization review and requiring certification of health care utilization review agents also apply to utilization review conducted in relation to claims in a worker's compensation health care network.

The Insurance Carrier must define the list of treatment that requires Utilization Review for USA WIN. The regulations have added physical and occupational therapy services to the current list of services that must be preauthorized by statute and allows the Commissioner of WC, by rule, to expand its list. Screening criteria used for utilization review and Retrospective Review must be consistent with the treatment guidelines, return-to-work guidelines, and individual treatment protocols. The Insurance Carriers' utilization review program must include a process requiring a

Treating Doctor or Specialist to request approval from USA WIN for deviation from the treatment guidelines, screening criteria, and individual treatment protocols where required by the particular circumstances of an injured worker's injury. Insurance Carrier, upon receipt of a provider's preauthorization request, must transmit a determination to the provider indicating if the proposed services are approved. All referrals to other providers must be made by a USA WIN Participating Network Provider.

Adverse determination means a determination by a utilization review agent that health care services provided or proposed to be provided to a patient are not medically necessary, are experimental, or investigational.

Appeals arising from decisions made in the service utilization review process or quality assurance process must be made orally or in writing. The appeal or complaint may be made by the patient or someone acting on their behalf, or by the patients' physician or healthcare provider.

When a medical dispute arises, it is referred by the Insurance Carrier to a member of its medical review committee. This committee is comprised of physicians appointed by Insurance Carrier with appropriate expertise and specialties to review the treatment issue(s) in dispute and will not include the physician who made the original decision. The committee members will review the medical treatment issue and make a determination whether to uphold the decision, obtain additional information, or reverse the decision. Anytime additional medical information is required or obtained through the reconsideration process it will be included in the review.

An employee, a person acting on behalf of the employee, or the employee's requesting provider may no 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. The reconsideration process will be completed within 30 days of the date that Insurance Carrier receives the request. At the completion of the reconsideration process, Insurance Carrier will notify all parties in writing of the decision. Such notice will include an explanation of the reasons for the decision, including any medical or clinical basis for the decision, the credentials of any medical provider consulted in the process and the state(s) of licensure for those providers. The parties will also be advised of the right to seek review of a denial by an independent review organization. Such review may be requested through the completion of the forms allowing for the request of an independent review, which are included with this notice. The forms are also available on the Texas Department of Insurance website: www.tdi.state.tx.us or by sending a request to:

**HMO Division
Mail Code 103-6A
Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104**

A request for an independent review must be filed no later than the 45th calendar day after the denial of reconsideration.

If USA WIN's Participating Network Provider has questions or needs assistance in completing the form, they may contact insurance or Texas Department of Insurance at the number provided on this form.

Insurance Carrier will promptly notify the TDI when there has been a request for independent review. Notice will be made via electronic transmission and will be on the form required by the TDI. The utilization review agent may access the TDI on working days between 7:00 a.m. and 5:00 p.m., Central Time, Monday through Friday, to obtain assignment of an independent review organization.

TDI will then advise Insurance Carrier and the injured worker of the independent review organization assigned to the case. Within 3 days of that notification, Insurance Carrier must provide the following to the independent review organization:

- All relevant medical records relating to the issue in dispute;
- Any documents relied upon for the utilization review decision by Insurance Carrier;
- A copy of the notification of the results of the internal review by Insurance Carrier;
- Any information provided to Insurance Carrier to support the appeal; and
- A list of names and phone numbers of any health care provider who has provided treatment and/or may have records relevant to the appeal.

After an independent review organization's review and decision under this section, a party to a medical dispute that disputes the decision may seek judicial review of the decision. The Division of Worker's Compensation and TDI are not considered to be parties to the medical dispute. A decision of an independent review organization related to a request for pre-authorization or concurrent review is binding. The Insurance Carrier is liable for health care during the pendency of any appeal, and the Insurance Carrier shall comply with the decision.

If judicial review is not sought under this section, the Insurance Carrier shall comply with the independent review organizations decision.

COMPLAINTS TO TEXAS DEPARTMENT OF INSURANCE

Any person, including a person who has attempted to resolve a complaint through USA WIN's complaint system process or attempted to resolve a dispute who is dissatisfied with resolution of the complaint, may submit a complaint to TDI. To be considered complete the complaint must include contact information including name, address, telephone number, a copy of the determination and any evidence provided to the Insurance Carrier for consideration.

Send complaint to:

**Texas Department of Insurance
HMO Division, Mail Code 103-6A
P.O. Box 149104
Austin, TX 78714-9104
Toll Free: 1-800-252-7031
Fax: 512-490-1012**

An online complaint form can be accessed at www.tdi.state.tx.us.

Send email complaints to consumerprotection@tdi.texas.gov

INSURANCE COMPLIANCE REVIEW

As often as the Commissioner deems necessary, the Commissioner or Commissioner's designated representative may review the operations of USA WIN to determine compliance with statutory and regulatory requirements. The review may include on-site visits to USA WIN premises. During on-site visits, USA WIN must make available to the TDI all records relating to USA WIN's or Insurance Carrier operations.

If requested by the Commissioner or Commissioner's representative, each provider, provider group, or third party with which USA WIN has contracted to provide health care services or any other services delegated to USA WIN by the Insurance Carrier must make available for examination by the TDI that portion of the books and records of the provider, provider group, or third party that is relevant to the relationship with USA WIN.

SUPPLEMENTAL INFORMATION

Pursuant to USA WIN's agreement with Participating Network Providers set out in Section 1(a) of the Health Care Service Provider Agreement, USA WIN has adopted the following policies and procedures for Provider participation in USA Worker's Injury Network (USA) that are applicable to those Participating Network Providers organized in the State of Texas or providing services under the Worker's Compensation statutes of Texas.

1. Provider may not send an invoice to or attempt to collect any amounts of payment from an employee who is employed in the State of Texas and subject to the Texas Worker's Compensation laws for injuries that are compensable under those laws under any circumstances, including the insolvency of the Insurance Carrier of the employee or insolvency of USA.
2. Provider must follow treatment guidelines; return-to-work guidelines and individual treatment protocols adopted by USA and set out in Exhibit A, Cost Containment Guidelines, to the Health Care Service Provider Agreement.
3. Provider may not deny treatment for a compensable injury to an employee solely on the basis that the treatment is not specifically addressed by the treatment guidelines used by USA or an Insurance Carrier.
4. USA may not refuse to renew a contract with a Provider because the Provider has, on behalf of an employee, filed a complaint against an Insurance Carrier that is a client of USA or

appealed a decision or requested reconsideration or independent review of the decision of an Insurance Carrier.

5. If the Health Care Service Provider Agreement with a Provider is terminated for any reason at Provider's request, Provider will continue to be paid or reimbursed (as applicable) the agreed upon rates (as set out in Exhibit B to the Health Care Service Provider Agreement) for care of an employee with a life-threatening condition or an acute condition for which disruption of care will harm the employee for a period of ninety (90) days from the termination date. If there is a dispute regarding the continuity of care for an employee being provided services by a Provider whose contract with USA has terminated, the parties must resolve the dispute through the complaint resolution process set out in Texas Insurance Code §§ 1305.401-1305.405 and TAC Title 28, Chapter 10, Subchapter G.
6. If the Health Care Service Provider Agreement is terminated for any reason other than its expiration:
 - a. USA agrees to give the Provider notice of termination at least ninety (90) days prior to the effective date of termination that it intends to terminate the Agreement.
 - b. The Provider, on receipt of the termination notice may request a review of the termination by USA's advisory panel within thirty (30) days from the date the notice is received.
 - c. For purpose of the review of Provider contract termination, USA will set up an advisory review panel that consists of three providers with the same licensure and the same or similar specialty as that of the terminated Provider with the authority to review the termination of Provider.
 - d. The USA advisory panel will be provided with the documentation necessary to review the termination and the advisory panel must complete its review prior to the effective date of the termination.
 - e. USA may not notify any patient of the Provider that the Provider is no longer a part of the USA WIN Network until the earlier of (i) the effective date of the termination or (ii) the date the advisory review panel makes a formal recommendation (assuming that the report of the advisory review panel confirms the termination).
 - f. If there is potential of imminent injury or harm to the health of an employee who is the patient of the Provider that is being terminated for suspension or termination of an applicable license to practice, or a fraudulent act, USA may terminate the Provider immediately and will immediately notify the employees (if any) receiving medical services from the Provider that the Provider has been terminated.
 - g. If a Provider terminates its contract with USA, USA will notify employees of the clients of USA who are receiving medical care from the terminating Provider as soon as practical and no later than the termination date that the Provider is terminating its agreement with USA.
7. Provider must post a notice to employees containing information required by Texas Insurance Code §1305.405 on the process for resolving workers' compensation health care network complaints in the office of the Provider. The notice must include the Texas

Department of Insurance toll free telephone number for filing a complaint and must list all workers' compensation health care networks with which the Provider contracts.

8. USA will furnish Provider a list of any treatments that require pre-certification or pre-authorization and the procedures to obtain that certification or authorization.
9. The Health Care Service Provider Agreement may not be interpreted in a manner that would allow the transfer of risk to an employee, as the transfer of risk is defined in Texas Insurance Code §1305.004(a)(26).
10. Provider and any subcontracting provider must comply with all applicable statutory and regulatory requirements under both the laws of the State of Texas and the United States of America.
11. Exhibit B to the Health Care Service Provider Agreement sets out the rates for medical services that are applicable to the Provider agreement with USA.
12. A Provider whose specialty has been designated by USA as Treating Doctor is a network Treating Doctor and agrees to any applicable provision as a Treating Doctor.
13. Billing by Provider and payment to Provider will be made in the manner and process set out in Texas Labor Code §408.027 and applicable rules.
14. Provider must provide treatment to injured employees who are presented to Provider through USA WIN Network and contracted INSURERS of the USA WIN Network.
15. USA will require contracted INSURERS to not use financial incentives or make payment to Provider that acts directly or indirectly as an inducement to limit medically necessary services.
16. Provider agrees to allow INSURER to effect a contingency plan in the event that INSURER is required to reassume functions from USA WIN as contemplated under Texas Insurance Code §1305.155.

FOR INTERNAL USE ONLY	
DATE RECEIVED	
CONCERN #	



COMPLAINT/GRIEVANCE FORM

Complaint Initiated by: Provider Employee Employer Carrier
 Complaint Involves: Service Medical Care Other

INITIATOR OF COMPLAINT

Name (Last, First):		
Address:		
City:	State:	Zip:
Telephone #: ()		

Employee Name:			Employer Name:		
Address:			Address:		
City:	ST:	Zip:	City:	ST:	Zip:
Telephone#: ()			Telephone#: ()		
SSN:					

Group Name:			Insurer:		
Provider Name:			Contact:		
Address:			Address:		
City:	ST:	Zip:	City:	ST:	Zip:
Telephone#: ()			Telephone#: ()		

Date of Injury:	Date of Disputed Action:
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**** Note:** USA Worker's Injury Network cannot thoroughly investigate this complaint/grievance without written consent to obtain copies of your medical records or other related documents. Records are kept confidential and used solely for the purpose of grievance resolution.

- Yes, I hereby authorize USA Managed Care Organization permission to obtain and review all medical and/or other related records. You may disclose my name and nature of this concern in order to obtain additional information. I agree to a Photostat and/or facsimile of this release being accepted, if necessary.
- No, I do not authorize disclosure of my name or nature of this concern in order to obtain additional information.

Complainant Signature: _____ Date: _____

