



## **PARTICIPATING PROVIDER MANUAL**

**UPDATED – MAY 2015**

*Prepared by*

Texas Mutual Insurance Company &  
Coventry Health Care Workers' Compensation, Inc.

*and its affiliate companies*

FOCUS Healthcare Management, Inc.

First Health

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**Section 1****Introduction and Overview**

Congratulations on your decision to participate in the Texas Star Network®, Texas Mutual’s exclusive workers’ compensation network. Thanks to quality health care providers like you, the Texas Star Network® has established a track record for getting injured workers well and back on the job. We appreciate your partnership, and we look forward to working with you long into the future.

The Texas Star Network® provides Texas Mutual policyholders with integrated services that include employment-related injury and occupational health care, in-network medical claim review and repricing, case management and other cost-containment services. Coventry administers the Texas Star Network®. Coventry also owns and operates the FOCUS and First Health companies. One of these organizations contracted with you to provide health care services to injured workers.

What follows is the Participating Provider Manual for the Texas Star Network®. We designed the manual to make it easy and convenient for you to do business with us. This is your reference for the administrative guidelines and procedures that apply to your contractual relationship with Coventry. Many of these principles are included in your Provider Agreement.

As a health care provider, you are the core of our business, and we share your commitment to providing the highest standards of medical care. The quality of your services is the most defining characteristic of our network. Texas Mutual Insurance Company constantly strives to improve our products and services to sustain our role as a leader in the workers’ compensation industry.

Again, thank you for joining the Texas Star Network®. We look forward to a long and productive partnership.

**Section 2****Client-Specific Provider Information**

Coventry contracts with a range of payers to serve as their Health Care Network (HCN) for treating injured workers. These clients include carriers, certified self-insurers, and political subdivisions. In many cases, the claims of these parties are managed by third-party administrators (TPAs).

Coventry administers the Texas Star Network®, Coventry also owns and operates the FOCUS and First Health companies. One of these organizations contracted with you to provide health care services to injured workers.

**Section 3****Health Care Network Program**

With the evolution of managed care in the workers' compensation industry, Texas Mutual partnered with Coventry to develop the Texas Star Network® and implement a managed care program specific to our needs. Today, the Texas Star Network® is the state's largest by claim volume and premium volume, making Texas Mutual the leader in certified workers' compensation health care networks.

Health care providers are an important part of any utilization management/cost-containment program. Texas Mutual's policyholders enroll in the network to ensure quality and cost-effective medical treatment. As a provider, your relationship with the Texas Star Network® is critically important to the success of Texas Mutual's ability to manage the entire cost of a work-related injury, including the medical cost and the cost of wage replacement on lost-time injuries. In addition to the very important role that you serve in the treatment of our customers' injured workers, we seek your cooperation in the areas detailed below.

### **Program Objectives**

We created the Texas Star Network® to: provide all injured workers with the best medical care in the most cost-effective manner and to get injured workers well and back to productive employment as soon as medically feasible.

### **Components**

**Alternate/Modified Work Program.** A significant component of Texas House Bill 7 is its focus on return-to-work. According to some estimates, between 25% and 34% of all injured workers never return to work. An aggressive return-to-work mentality is therefore critical for success in the new health care network environment. Thus, whenever an immediate, full-duty return-to-work is not possible, our customers expect that alternate or modified-duty work that is within the patient's physical capacities will be pursued.

**Case Management.** When injuries or illnesses occur, a telephonic case manager or a field case manager may be assigned. The case manager's role will be to work with all parties to identify and coordinate return-to-work opportunities early in the claim. Case managers may also assist in the communication process among providers, injured workers, and claims adjusters as necessary.

**Utilization Review/Preauthorization.** Coventry is a licensed utilization review agent in Texas. It reviews medical treatment for appropriateness, necessity and duration on behalf of Texas Mutual Insurance Company. Utilization review agents like Coventry employ nationally accepted treatment protocols and guidelines, and, where applicable, specific treatment protocols and guidelines that are promulgated under Texas workers' compensation legislation. In addition, Texas House Bill 7 allows Health Care Networks to establish their own guidelines and preauthorization requirements.

**Provider Bill Audits.** Medical bills relating to claims will be reviewed to ensure compliance with coding guidelines established by the Centers for Medicare & Medicaid Services, National Council on Compensation Insurance, and the American Medical Association, and to ensure reimbursement according to the rates that you have contracted with Coventry, FOCUS, First Health, or Texas Mutual.

When medically necessary services are available within the Network's service area, participating providers are expected to refer injured workers only to other Network specialty providers and hospitals. If you do not have a copy of the

network provider directory, you can obtain a list of providers in your area by calling Coventry’s Network Administration Department at (888) 252-5075 (Monday–Friday, 8AM–6PM Central). You can also visit [texasmutual.com/hcn/provdir.shtm](http://texasmutual.com/hcn/provdir.shtm) to search for Texas Star Network® providers or specialists in your area.

**Section 4**

**Confidentiality and Privacy of Health Care Information**

**Patient Information and the Health Insurance Portability and Accountability Act (HIPAA)**

The Texas Star Network® takes the privacy and security of patient information very seriously. As a provider in the Network, you have a responsibility to maintain the confidentiality of patient information in accordance with all applicable federal/state laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA). There are two major components to HIPAA: 1) health insurance reform, and 2) protecting the confidentiality of a patient’s health information.

The portion of HIPAA that involves patient confidentiality includes standards for protecting the privacy and security of confidential health information. If you are a covered entity under HIPAA, you may have implemented new procedures and technology for the interchange of medical information electronically, as well as established specific policies and procedures regarding the security and privacy of medical information. Your employees have a duty to strictly maintain patient confidentiality and privacy and to refrain from revealing any information concerning patients other than in accordance with HIPAA.

If questions arise regarding an obligation to maintain the confidentiality of information or the appropriateness of releasing information, you should seek guidance from the Department of Health and Human Services at [www.hhs.gov](http://www.hhs.gov) or the Office for Civil Rights at [www.hhs.gov/ocr](http://www.hhs.gov/ocr).

**Section 5**

**Coordination of Medical Services**

The Network strives to ensure the delivery of quality medical care in an efficient manner by offering a network of return-to-work-oriented providers. Dedication to the delivery of a provider network based on a philosophy of return-to-work principles guides us in building and maintaining a network that represents a select group of occupational health centers, physicians, allied health professionals, ancillary providers, and hospitals. These providers have affiliated with us to create a program to reduce the overall cost of medical care, lost employee productivity, and lost-time wages in the workers’ compensation arena.

In addition to the very important role that you play in the treatment of our customers’ injured workers, we seek your cooperation in the following areas.

**Coverage for emergency and urgently needed care provided within and outside the service area.** Care that is categorized as emergency (either a medical or mental health emergency) is available and accessible 24 hours a day, 7 days a week, without restrictions as to where the services are rendered. All participating emergency care facilities are

listed in the Provider Directory and at [texasmutual.com](http://texasmutual.com). You can also locate providers and facilities by calling our Network Administration Department at (888) 252-5075 (Monday–Friday, 8AM–6PM Central). Regardless, if emergency care is necessary, an injured worker may be treated by network or out-of-network providers.

**Referrals.** The Texas Star Network® was designed to deliver consistent, quality care to injured workers. To ensure consistency, the program requires providers to refer injured workers to other participating providers, including hospitals. The network does have an exception process for out-of-network referral requests and cases where the injured worker is seeking emergency care. Except for emergencies, a network shall arrange for services, including referrals to specialists, to be accessible to injured employees within the time appropriate to the circumstances and condition of the injured employee, but not later than 21 calendar days after the date of the original request. This will be accomplished by triage coordinators, nurse case managers, or claims adjusters.

A medical provider should contact the treating doctor for authorization before referring the patient to other participating or non-participating providers. Participating providers will provide or arrange for the provision of health services pursuant to the terms of the referral authorization. The medical provider will notify the patient’s treating doctor of all admissions.

All referrals authorized by the Network are to be made to participating Network providers, unless medically necessary treatment, care, and attendance are not available and accessible to the injured worker in the provider network. Each participating provider has contractually agreed that if an injured employee requires medical services outside the scope of the participating provider’s expertise, the injured employee will be referred to another participating provider. If, in the participating provider’s judgment, no participating provider can provide the necessary medical services, the participating provider agrees to refer the injured employee to a provider that is not a member of the network only after obtaining the approval to do so from the Network Administration Department.

**Initial Treatment.** Except for emergency services, covered employees must receive initial covered services from a treating doctor participating in the Network, unless the employee has chosen to receive care from his or her HMO primary care doctor in accordance with Texas regulations and network policies. The process outlined by Texas law and by the Network is that the employee receives all initial covered services from a primary care provider participating in the Network. Employees must be notified individually, and notification materials must also be available at the workplace with the employee’s rights in this regard. As part of these notification materials, the employee will have access to a provider directory listing all the treating doctors available within the certified service area.

**Treating Doctor Changes.** The network allows injured workers to change their treating doctors once without approval, but injured workers must notify the network. Subsequent treating doctor changes require network approval. Alternate and subsequent treating doctors must be participating Network providers. The case manager, claims adjuster or their designee will notify all appropriate personnel, including the current treating doctor, claims adjuster and any other appropriate parties of the request. Additional requests will be managed through the established Network grievance process.

**Designated Doctor Exams.** A doctor who has contracted with or is employed by an authorized workers’ compensation health care network established under Chapter 1305, Insurance Code, (network doctor) may not perform a designated

doctor examination, as those terms are used under the Texas Workers’ Compensation Act, for an employee receiving medical care through the same network (TAC Title 28, Part 2, §126.7 (a)). If you receive a request to provide a designated doctor exam by the Texas Department of Insurance, Division of Workers’ Compensation (DWC) for a Texas Star Network® patient, please contact the DWC and request that the exam be reassigned to a non-network provider.

**Section 6** **Texas Star Network® Preauthorization Requirements**

For your convenience, a link to the Texas Star Network® preauthorization list can be found on Texas Mutual’s website ([www.texasmutual.com/hcp/preauth.shtm](http://www.texasmutual.com/hcp/preauth.shtm)). This list is not intended to be comprehensive or all-inclusive. Health care is an ever-evolving science, so procedures and treatments requiring prior approval will also evolve. Participating Treating Providers should therefore verify specific preauthorization requirements by referring to the updated list posted on the website.

**Hospital/ASC**

- All non-emergency hospital or ASC (inpatient, outpatient, and observation) admissions including principle scheduled procedures and length of stay. Preauthorization request should include specific hardware, implantables, external delivery system, etc. to be utilized.

**Surgery/Procedures/Integral Devices**

- All non-emergency surgeries represented by AMA CPT codes 10010-69990 and/or G codes which represent a surgical procedure performed in a setting or place of service other than the doctor’s office [POS 11]. Preauthorization request should include specific hardware, implantables, external delivery system, etc. to be utilized.
- All Botox Injections
- All spinal injections (including, but not limited to):
  - Epidural Steroid Injection
  - RFTC or Cryotherapy/Cryoablation
  - Sacral Iliac Joint Injection
  - Facet Injection
  - Medial Branch Block
- Trigger Point Injections (represented by AMA CPT 20553)
- Bone Growth Stimulators
- Discograms
- Implantable Drug Delivery System

- Investigational or experimental procedures or devices as determined by ODG or listed as an AMA Category III Code.
- Stimulator Devices (including, but not limited to):
  - TENS Units
  - Interferential Units
  - Neuromuscular Stimulators
  - Dual Units
  - Spinal Cord Stimulator
  - Peripheral Nerve Stimulator
  - Brain Stimulator

**Physical Medicine**

- All Chiropractic Treatments (including manipulations and office visits).
- Manipulations under Anesthesia (MUA)
- All Physical Therapy/Occupational Therapy (unless requestor or rendering provider/facility is participating through Align)
- Biofeedback

**Diagnostics**

- All Initial and Repeat MRI and CT Scans
- Bone Density Scans

- Unless otherwise specified in this list, all repeat individual diagnostic studies (series) having a billed amount greater than \$350.
- Surface Electromyography (EMG)

**Other**

- Durable Medical Equipment (DME), Prosthetics and/or Orthotics, greater than \$500.00 billed (purchase or accumulated rental or combination of rental/purchase).
- Gym Memberships
- Texas Department of Insurance, Division of Workers’ Compensation (DWC) Pharmacy Closed Formulary per 28 TAC §134, Subchapter F.

**Alternative Treatment (including but not limited to):**

- Acupuncture Outside ODG
- Acupressure
- Yoga

**Rehab Programs (including, but not limited to):**

**Psychological and/or Psychotherapy (including but not limited to):**

- Subsequent Evaluations
- Subsequent Tests or Testing
- All Therapy
- All Biofeedback

- Work Conditioning
- Work Hardening
- Chronic Pain Management Program
- Medical Rehabilitation
- Brain and Spinal Cord Rehabilitation
- Chemical Dependency Programs
- Weight Loss Programs

**Nursing Home (including, but not limited to):**

- Skilled nursing facility, including skilled care within the same facility.
- Convalescent Care
- Residential Care
- Assisted Living
- Group Homes

Coventry and Texas Mutual’s teams will work through utilization and retrospective review processes to ensure medical care meets the network’s standards for quality and efficiency, and that it is based on the network’s return-to-work philosophy and treatment protocols. Through this process, all reconsiderations of adverse determinations of utilization review requests will be managed.

**Section 7**

**Reconsiderations and Adverse Determinations of Preauthorization Requests**

**Requesting a reconsideration of an adverse determination during the course of treatment.** Injured workers and doctors may ask for reconsideration of an adverse determination regarding requested treatment. This reconsideration must be conducted by a provider other than the provider who made the original adverse decision. Full compliance with all applicable timelines for acknowledgement, receipt, and performance of the reconsideration are expected.

**Requesting an independent review of adverse determinations within the provider network during the course of treatment for a work-related injury.** The Network shall have a policy within the utilization review department for allowing injured workers, their provider, or a person acting in their behalf to request an independent review of an adverse determination of a request for reconsideration. The Utilization Review agent will provide to the independent review organization any medical records of the employee relevant to the treatment of the work-related injury. Utilization review will also provide any documents, including treatment guidelines, used by the person in making the determination, the response letter described in Insurance Code 1305.354(a) (4) and 10.103(a) (4), any documentation and written information submitted in support of the request for reconsideration, and a list of the providers who provided care to the employee and who may have medical records relevant to the review. Full compliance with all applicable timelines for acknowledgement, receipt, and performance of the reconsideration are expected.

**Section 8**

**What House Bill 7 Means for You**

The Texas Department of Insurance, Division of Workers’ Compensation offers information about House Bill 7 and other legislation that affects the workers’ compensation system. The site includes an overview of House Bill 7, a list of FAQs and other information tailored for health care providers. Visit <http://www.tdi.texas.gov/wc/indexwc.html> to take advantage of the free tools.

**Section 9**

**Treatment Protocols and Return-to-Work Guidelines**

As required by House Bill 7, the Network has adopted evidence-based treatment guidelines, including the Official Disability Guidelines (ODG) guidelines and the European Guidelines for Management of Chronic Low Back Pain. In addition, we have adopted the Medical Disability Advisor (MDA) as our return-to-work guidelines. All providers are required to follow these guidelines when treating injured workers in the Network. Our adjusters, case managers and Utilization Review personnel will also use these guidelines to determine what treatment is appropriate as treatment

plans are established and monitored. Practice parameters and protocols may be accessed through the following websites:

**Official Disability Guidelines (ODG):** <http://www.disabilitydurations.com>

**European Guidelines for Management of Chronic Low Back Pain:** <http://www.backpaineurope.org>.

**Medical Disability Guidelines (MDA):** <http://www.medicaldisabilityadvisor.com>.

By complying with the network’s treatment and return-to-work protocols, you help ensure all injured or ill employees get fair, quality treatment. While the network requires participating providers to use these treatment guidelines, we do recognize some situations will call for different treatment protocols. To ensure guidelines are maintained, and to comply with the requirements of House Bill 7 and the Texas Department of Insurance, compliance monitoring will be conducted.

## Section 10

### Bill Submission and Completion

Providers should send all invoices for workers’ compensation medical expenses directly to Texas Mutual Insurance Company at PO Box 12029, Austin, Texas 78711-2029. Texas Mutual will reprice bills according to contracted reimbursement amounts. Billing should comply with all state-specific workers’ compensation legislation. Use of the appropriate billing forms is essential for prompt bill processing. To expedite process, we ask that all bills be checked for accuracy prior to submission.

**CPT-4 Codes and HCPCS Codes.** CPT-4 and/or HCPCS codes must be used for all claims submitted on the CMS-1500 forms. CPT-4 code and/or HCPCS code books are available at the following address: *American Medical Association, 515 N. State Street, Chicago, IL 60610, (800) 621-8335*

**ICD-9 Codes.** Diagnoses should be indicated by ICD-9 codes on the CMS-1500 and UB-92 forms. ICD-9 code books are available at the following address: *Documents, U.S. Government Printing Offices, Washington, DC 20402*

**Balance Billing.** Bills will be repriced to the negotiated contract rate. Providers may not bill patients or employers for the remainder of the balance, except as permitted by law.

**Bill Submission.** Texas Division of Workers’ Compensation (DWC) Rule §133.20 states that a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. Additionally, DWC Rule §133.1 states that the bill must be complete before submission to the carrier.

**Employer Payment Arrangements.** Medical providers are not prohibited from making payment arrangements with employers. However, Rule §133.20 (j)(1) states that the health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to: (A) prompt payment, as provided by Labor Code §408.027; (B) interest for delayed payment as provided by Labor Code §413.019; and (C) medical dispute resolution as provided by Labor Code §413.031. Additionally, §133.20 (j)(2) states that when a health care provider bills the

employer, the health care provider shall submit an information copy of the bill to the insurance carrier, which clearly indicates that the information copy is not a request for payment from the insurance carrier.

**Requests for Reconsideration.** Per rule §133.250, health care providers who are dissatisfied with Texas Mutual’s final action on a medical bill, may request that Texas Mutual reconsider its action. The reconsideration request must be submitted no later than 10 months from the date of service and shall: (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill, (2) include a copy of the original explanation of benefits, if received, or documentation that a request for an explanation of benefits was submitted to Texas Mutual, (3) include any necessary and related documentation not submitted with the original medical bill to support the health care provider’s position, and (4) include a bill-specific, substantive explanation that provides a rational basis to modify the previous denial or payment.

Texas Mutual will review all reconsideration requests for completeness and may return an incomplete reconsideration request no later than seven days from the date of receipt. Texas Mutual will take final action on a reconsideration request within 30 days of receiving the request for reconsideration. Texas Mutual will provide an explanation of benefits for all items included in a reconsideration request. Per the rule, a health care provider shall not resubmit a request for reconsideration after the insurance carrier has taken final action on the reconsideration request.

Section 11

Provider Relations

The *Texas Star Network*® provider relations team is here to help you get the most out of your participation in the network. The team is your go-to source for questions, concerns and suggestions. They work closely with Texas Mutual’s other departments to ensure we listen and respond to your needs.

Provider Relations Representatives are available to assist you with:

- Referrals within the Health Care Network;
- Listings of providers within your geographic area;
- Grievance procedures;
- Changes to your demographic information; and
- Issues regarding the use of your contract.

The Texas Star Network® Provider Relations Department can be reached at (800) 381-8067, Monday–Friday, 8AM–6PM Central.



## Section 12

### Internet Access

Coventry, our network administrator, has developed a website that includes everything providers, employers and injured workers need to know about workers' compensation health care networks. We encourage you to visit <http://www.coventrywcs.com> to:

- Learn more about Coventry and its services;
- Access the provider website;
- Communicate with Coventry via email;
- Access referral information on providers in Texas;
- Notify Coventry of changes that have occurred in your practice;
- Keep apprised of legislative changes that affect the state(s) in which you conduct business, as well as general industry news and features; and
- Access other educational resources.

To access a *Texas Star Network*® provider list, please visit [www.texasmutual.com/hcn/provdir.shtm](http://www.texasmutual.com/hcn/provdir.shtm).

The site allows you to conduct the following searches:

- Nearby Providers – allows you to search for providers using characteristics you specify, such as specialty.
- Look up a Provider by Name – allows you to search for a specific provider by name.
- Directory – allows you to request a radius based-directory to be generated.

If you need help accessing this site, call our Texas Customer and Provider Relations Department at (800) 381-8067 (Monday–Friday, 8AM–6PM Central).

## Section 13

### Provider Site Visits

In accordance with requirements set forth in the Texas Workers' Compensation Health Care Network Act and related rules, site visits of treating doctor locations will be performed by the Network within the first year after certification of the Texas Star Network® with the Texas Department of Insurance. Treating doctor specialties include emergency medicine, family practice, general practice, general preventive medicine, internal medicine, occupational medicine, and urgent care physicians. Furthermore, the network may conduct a site visit to any office at any time for cause. Health care facility site visits are also required, but may be waived if the facility is accredited by an approved accrediting body.

The evaluation will assess accessibility, appearance, appointment availability and space, as well as record organization, documentation, and confidentiality. If the site offers services that require certification or licensure, such as laboratory or radiology services, these will also be reviewed during the visit. Furthermore, the evaluation may assess other criteria

requested by the Medical Director, including but not limited to facilities or services related to a complaint or event, evaluation of medical records, and/or equipment.

New locations will also require a site visit, which will be identified and conducted through periodic review.

**Section 14**

**Provider Monitoring**

The Network must conduct provider monitoring on its members’ performance. Monitoring will include Medicare/Medicaid sanctions/limitations, state licensing board sanctions/limitations, complaints, and Texas Department of Insurance, Division of Workers’ Compensation information. When occurrences of poor quality are identified, the Network will take appropriate action, which may include but not be limited to a site visit, medical record review, Medical Director review, and/or termination.

Texas Mutual Insurance Company conducts economic profiling studies to compare individual or provider groups to other providers in an effort to evaluate trends such as utilization, cost per claim, or other measures. These reviews are subject to the notice provisions of Texas Department of Insurance Rule 10.42(d) 28 TAC §10.42.

**Section 15**

**Provider Demographic Changes and Updates**

It is very important that you provide us with written notice of demographic changes within 10 business days.

Demographic changes include:

Type of Change	Method of Submission		
	Fax: (615) 224-9123	Email: coventry_dataupdates@cvty.com	Mail: Texas Star Network 720 Cool Springs Blvd., Ste. 300 Franklin, TN 37067 Attn: Network Operations
Name Change	X	X	X
Tax Identification Number (TIN)	X	X	X
Address (Billing or Practice)	X	X	X
Addition or Closing of Office	X	X	X
Group Participation	X	X	X
Termination of Provider Within Existing Practice	X	X	X

**Data Integrity Verification**

The Texas Star Network® verifies all health care network providers’ basic demographic information on a quarterly basis. You will be contacted via fax, phone or other means to verify your name, address, tax identification number and phone number. It is imperative that you or a designated person in your office verify your information so that you remain an active health care network provider.

Section 16

Complaint and Grievance Procedures

The *Texas Star Network*® complaint procedure is available to any participating provider, employer, employee or employee’s authorized representative. We define a “complainant” as an employee, employer, provider or authorized representative designated to act on behalf of an employee who files a complaint.

The *Texas Star Network*® defines a “complaint” as any dissatisfaction expressed orally or in writing by a complainant to a network regarding any aspect of the network’s operation, including dissatisfaction related to medical fee disputes and the network’s administration, and the manner in which service is provided.

A complaint does not include: 1) 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 2) an oral or written expression of dissatisfaction or disagreement with an adverse determination.

A complaint must be filed with the network’s Grievance Coordinator no later than 90 days from the date the issue occurred.

The *Texas Star Network*® will not engage in any retaliatory action against an employer, employee or a person acting on behalf of the employer or employee who has filed a complaint against the network.

The steps to file a complaint are as follows:

1. A complainant can notify the *Texas Star Network*®. Grievance Coordinator of a complaint orally or in writing via mail, email, or fax. Complaints should be forwarded to:

*Texas Star Network*®, Attention: Grievance Coordinator, 3200 Highland Avenue, Downers Grove, IL 60515  
Grievance Coordinator – Fax (630) 737-2077; [ComplaintsandGrievances@cvty.com](mailto:ComplaintsandGrievances@cvty.com)

The Grievance Coordinator is also accessible through the *Texas Star Network*® customer and provider relations department at (800) 262-6122, (Monday–Friday, 8am–6pm Central). This telephone number is routinely given to participating providers via provider updates and Participating Provider Manuals, and to employers and employees through network educational materials. The toll-free telephone number provides reasonable access to the Grievance Coordinator without undue delays. After hours calls are recorded and messages responded to on the next business day.

2. Upon receipt of the complaint, the Grievance Coordinator will document each complaint in a confidential database. Data recorded includes the date received, classification of the complaint, information regarding the complainant and a description of the complaint. Prior to resolution, the status of the complaint activity will be updated on a regular basis.

3. The Texas Star Network® will confirm receipt of a complaint within 7 days and notify the complainant in writing that the complaint has entered a formal resolution process. We will also provide a copy of the complaint procedures and deadlines to the complainant.

The Grievance Coordinator reviews all complaints for follow-up and resolution. If the complaint is of a clinical nature, a Texas Star Network® Medical Director will be consulted.

4. The Texas Star Network® will provide a letter to the complainant no later than 30 days from the initial receipt of the complaint. This letter will explain the resolution of the complaint, specific reasons for the resolution, and the specialization of any physician or other provider who was consulted during the resolution process.

The resolution letter will also advise the complainant that if he/she is dissatisfied with the resolution of the complaint or the complaint process, he/she may file a complaint with:

*Texas Department of Insurance - Managed Care Quality Assurance Office, Mail Code 103-6A, P.O. Box 149104, Austin, Texas, 78714-9104*

5. If necessary, a copy of the resolution letter will be supplied to the appropriate agency, as designated by the state.
6. The Texas Star Network® will maintain a complaint log and categorize each complaint type as one or more of the following:
  - Quality of care or services
  - Accessibility and availability of services or providers
  - Utilization review, as applicable or in retrospective review
  - Complaint procedures
  - Health care provider contracts
  - Bill payment, as applicable
  - Fee disputes
  - Miscellaneous
7. Complaints shall be trended on a quarterly basis and the results reported to the Quality Improvement Advisory Committee for review and recommendation, as appropriate.
8. The Texas Star Network® shall maintain records of complaints for a period of three (3) years from the date the complaint was filed.

INTENT: The complaint procedure is intended to be self-executing and easy to use. For example, a complainant may call the Grievance Coordinator directly without completing this form, and the Grievance Coordinator may complete the form for the complainant. A review regarding the requested medical care will begin immediately, and a decision made within 30 days of receipt, unless additional information is required from outside the service area. The review period may be extended by mutual agreement between the complainant and the Grievance Coordinator, with notice provided to all other participating parties.

The complainant's participation in the complaint process is important to the resolution of medical issues. Individuals reviewing the complaint may need to speak directly with and receive input from the complainant. If the complainant is unable to participate actively in the complaint process, a patient advocate may participate on behalf of the complainant.

A copy of the *Texas Star Network*® Formal Complaint Form is provided at the end of this document.

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Section 17

**Texas Star Network® Provider Newsletter and Education**

Health care providers are crucial to an effective workers' compensation system. Texas Mutual wants to partner with providers to ensure they understand the system. That is why we publish a network provider newsletter and provide other educational materials. We encourage you to visit [texasmutual.com/news/cw.shtm](http://texasmutual.com/news/cw.shtm) to access these free resources.

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Section 18

**Pharmacy Closed Formulary Adoption by the Division of Workers' Compensation**

The Texas Department of Insurance, Division of Workers' Compensation (DWC), has adopted a pharmacy closed formulary that is applicable for claims with a date of injury on or after September 1, 2011. The closed formulary also applies to claims with a date of injury prior to September 1, 2011 beginning September 1, 2013. In order to determine if a medication requires preauthorization, please refer to ODG, Appendix A. For your convenience, DWC has posted the list of drugs that require preauthorization, as published by ODG, Appendix A, on its website, [www.tdi.texas.gov/wc/dm/index.html](http://www.tdi.texas.gov/wc/dm/index.html). Please click on the "N" Drug List line item. Please note that Preauthorization is not required for Drugs with a "Y" status or not listed (and not experimental or investigational) in ODG, Appendix A. "Y" status drugs are available for the majority of the Drug Classifications.



Texas Star Network® FORMAL COMPLAINT FORM

Date Received: \_\_\_\_\_

INITIATOR OF COMPLAINT

Name:
Address:
City:                      State:              Zip:
Telephone #: (     )

Complaint Initiated by:              Provider               Employee               Employer               Carrier

Complaint Involves:              Service               Medical Care               Other

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

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

Please describe your complaint in detail below. Include dates, names and the specific resolutions that you feel might remedy the situation. You have up to 90 days from the date of the dissatisfaction to file a formal complaint. **PLEASE ATTACH COPIES OF APPLICABLE MEDICAL RECORDS TO THIS FORM.**

Date of Injury: \_\_\_\_\_ Date of Dissatisfaction: \_\_\_\_\_

Please describe\*\*: \_\_\_\_\_

\*\*If you need more space, please use additional sheets.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Mail this form to the address noted below, or fax to (630) 737-2077. For questions, please call (800) 262-6122

Texas Star Network®  
Attention: Grievance Coordinator  
3200 Highland Avenue  
Downers Grove, IL 60515