IMO Guide in Choosing a Network

The ***IMO Network Guide*** is a collective selection of frequent "Questions and Answers" from an IMO perspective as a Certified Health Care Network (HCN-1305) with over nine (9) years' experience in the network environment. A Quick Reference Guide of IMO and its managed care suite of services can be found on our website at *www.injurymanagement.com.*

What questions are important to ask when choosing a network? We hope this guide is beneficial to any buyer wanting to be more educated on this topic, specifically an HCN/1305 Network.

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Introduction – Understanding the Carrier Choice

Let's start with a general overview. "Why do I need a network?" The first thing to understand is you do have a **choice.** If you are a carrier, a contract with more than one HCN is allowed and not often considered. Even if the carrier certified is its own network, or is contracted with more than one network. The choice less considered is that a carrier can use various certified networks based on full policyholder groups. The choice to offer to a carrier's request and customize a Texas brand and boutique style of delivery may be more attractive than a national appeal with a Preferred Provider Organization (PPO) style and delivery. If you are an employer, you can choose to be in a "non-network" environment, but there are some risks to consider.

Allowing "business as usual" to occur for injuries in the State of Texas can result in diminished medical utilization management outside of Pre-Authorization. There is risk in not having contracts and accountability agreements with providers. There is risk in clinging to the old PPO discount mentality, which is now illegal in Texas effective January 1, 2011.

Choosing a network is critical for more reasons than just having a discount. Putting aside any preconceived notions, it is important for you to know what questions to ask and where to go for reliable information. Start looking now if you have not already. Reading this guide is a good place to begin! It will help you to better understand why a network's philosophy, pricing, delivery, outcomes, experience and ownership of oversight are crucial.

Lastly, it will be difficult to survive medical cost increases without a managed care network. The right partner by your side is the most important decision to make upfront.

Network Types Defined

- In a **504 Inter-local Network,** the rules and regulations are scarce and the provider contracts are ultimately the responsibility of the governmental entity. “Legacy” and “gap” claims are allowed and specialists and hospitals are not required. The provider contracts are signed and managed by an agent on the behalf of the carrier/pubic entity; however, the carrier must sign the contract with the provider. The inter-local agreement can include various public entities; however, it is not unusual that a 504 can be successful as a stand-alone public entity. The 504s’ are usually owned and operated by either a direct carrier, a broker and/or a legal representative as the agent or administrator for the 504.

- In an **HCN/1305 Certified Network** the rules and regulations are the advantage as the Network is responsible for the Network. Legacy claims are allowed if appropriate or at the discretion of the network. Positive trends and cost savings are proven effective. The administration of the network and direct credentialing contracting of 22 specialist per county allows for accessibility and continuity of care to exist. While the HCN’s are usually owned and operated by direct networks or carriers at large. The contract must be between a network and carrier directly.

Frequent Network Questions -

1. **How do I find a Certified Health Care Network (HCN)?**

   There are 30 HCNs in the State of Texas, all approved and certified by the Texas Department of Insurance (TDI). However, all have various dynamics, owners, philosophies and methods of managing the injured employee. Visit *tdi@state.gov.net* for more information on specifics and coverage.

2. **What is the TDI Network Report Card? How can it help me in choosing a network?**

   The Texas Department of Insurance (TDI) through its Workers' Compensation Research and Evaluation Group was mandated in the 79th Texas Legislature to publish an annual Report Card. This Report Card compares the performance of networks with each other as well as with non-network claims on a variety of measures including:

   a. Health Care Costs
   b. Utilization
   c. Satisfaction with Care
   d. Access to Care
   e. Return to Work
   f. Health Outcomes

   To download the complete document, please visit *www.injurymanagement.com* and click "TDI Network Report Card Results" on the homepage.

3. **Is it better to go with a network that has full State coverage, or one that is specific to my location?**

   It depends on what is important to you. Networks with full state coverage are usually the old style, turn-key PPO Networks that have met the 1305 requirements and can offer full county coverage for an employer who has employees statewide. However, if you select a network that has selective providers with isolated and approved specific counties, this often demonstrates the network may have directly or organically grown its network through its credentialing and contracting providers, which then allows for a more contained network. Both may have advantages and disadvantages based on what "network fit" you are trying to reach.

   Keep in mind that when a non-network provider is treating an injured employee within the network; the network administrator can determine if they will approve an out-of-network provider based on needs. The network can then proceed forward with an out-of-network nomination if warranted.

Often times, the out-of-network providers may be in a network access plan approved by TDI that provides time to leverage the nomination process and allow the network to fully select quality providers. This then relieves the pressure of not requiring a full state coverage, while allowing a more customized network to be in place. Therefore, not having full state coverage may not be a hindrance as it does allow selective nomination in counties that meet an access plan to complete the specialist county needs and meet the necessary medical needs.

4. **Can provider discounts still apply in a network environment?**

Yes, providers can offer discounts to a network, either below or even above the Texas Medical Fee Schedule. In fact, the only way a provider can enter into a discount rate is through a network contract.

5. **Do I have the right claims administrator to effectively manage the network claims?**

Generally, it is important to determine if the third-party administrator and insurance carrier have experience handling claims covered by a certified network and if they have been audited by DWC through the process of the network "Report Card." Primarily, the focus of this decision must rely on the TPA's philosophy, corporate culture and mission in managing the claim early on and how effective the interface between the network team, the carrier, and the TPA demonstrates. Can the TPA provide you and the network, the necessary benchmarks of claim data such as medical costs, lost days of work, and activity related to legal costs and ancillary service utilization, to name a few. These are important questions to ask your TPA to ensure that their knowledge and commitment to working with your selected network is evident.

The TPA is usually the data keeper of the claims data, so the effectiveness and ability to measure claim cost *at all levels* is significant. Both the TPA and the network functions are different and must be interfaced and managed effectively in the network environment.

6. **Are there benefits for Cost Containment services such as Medical Bill Review, Pre-Authorization and Case Management to be a part of the network or should they be separate?**

It is possible to have two different companies doing network access and Cost Containment services. With the right interface and integration, there are pros and cons within the delivery process.

For example, there are current networks that provide full cost containment services to *optimize potential of managed care and accountability within the delivery of the care.* The benefits include:

a. The provider network fees are managed and filtered into the Medical Bill Review system. Therefore, allowing an accountability process for correct contracted fees and provider relations are enhanced.

b. The certified network has authority to modify the Pre-Authorization list and utilize the choice of evidence-based guidelines necessary. Conducting Preauthorization services within the network allows close scrutiny of the network provider's request, patterns of treatment, and evidence-based practices. This allows the quality improvement process to occur with the providers as the network evaluates and determines effective treatment outcomes and provider performance.

7. How would I assess which network is the right fit for me?

The best way to compare and determine which network is the "right fit" is to conduct an "RFI" (Request for Information) or "RFP" (Request for Proposal). It is important to listen to networks when determining if their experience, flexibility and common philosophy are compatible with your expectations.

8. What are some differences among networks that may provide more insight?

a. Who owns the network? Is the network provider panel outsourced from another company? If so, you may want to ensure the network is in compliance with TDI regulations as they relate to the client contract arrangements between parties.
b. What other services are outsourced – management agreements, Case Management, credentialing, quality improvement programs?
c. How are the provider panels selected, nominated and credentialed? Who is responsible for the accountability of the provider performance?

    i. Who are the treating doctors in the network? We find that some networks allow all type of specialties as treating doctors.
    ii. How does the network score compare to other networks in the TDI "report card?"
    iii. Are Case Managers involved in the network? It is required that certified Case Management occurs in a network environment. In addition, some form of Case Management and Field Case Management oversight function with return to work focus are critical functions of the network's required quality improvement program. This may or may not be part of the network access fee. Whether it is included or not in the fee you should consider it to be an integral component of the network services. This is because this function will be largely responsible for the successful network outcomes.

9. What are some of the main functions of a Certified 1305 HCN?

a. Confirm notice of network requirements;
b. Confirm selection of treating doctor, and or change of treating doctor in network;
c. Approve or disapprove out of network provider;
d. Ensure satisfaction of care;
e. Ensure Telephonic / Field Case Management needs are met;
f. Measure medical and indemnity cost benchmarks;
g. Ensure provider education and responsibilities are achieved;
h. Make certain that provider medical documentation is retrieved and reviewed; and
i. Ensure evidence-based practice is followed.

10. **How do networks bill for services? What are the billing methodologies?**

Networks may bill for their services in one of the following methods:

a. *Network Access Fee*: May include, a) Provider Access; b) TDI Data Calls; c) Quality Improvement Programs; d) Complaint Process; e) Telephonic Case Management based on criteria for medical only and / or lost time cases; f) Credentialing and contracting and provider panel maintenance.
b. *Percentage of Savings:* This method is familiar to the way the past voluntary Networks billed.
c. *Workers' Compensation Policy Discount Premium:* In exchange for a network choice, this model often has a separate network billing structure based on percentage of savings. It is unclear as to how the payment process works for network functions. However, it appears that when this discount premium pricing is offered, there are other "percentage of savings" expenses incorporated in varying ways into the pricing schedule.
d. *Cost Containment Services Fees:* Through Cost Containment service fees for example, $40 per bill is charged for Network administration and this covers the administration of the network access. Still other services such as Case Management, a medical director's role, Pre-Authorization, and similar items may still be line items billed directly.
e. *Per Employee Per Month Fee:* This is based on a fee for all possible employees who access the network, much like the fee found in a group Health Care setting.

11. What should be the primary mission and benefit of using a network?

The primary mission of the network is to reinforce positive provider relations with its managed care metric components. This approach should maximize the quality of Health Care, cost effective outcomes, satisfaction of care, early intervention and return to work.

12. What is the implementation process and how long does it take to kick off a network?

The overall network implementation can take from three weeks to forty-five days, based on the internal resources and the dedicated teams organization.

The Network and carrier would mutually agree upon the responsibilities among the carrier, its TPA and the selected network. The arrangement would be clearly described in the contracts between the parties. A network contract *cannot* be between the TPA and the carrier.

There are various implementation steps. However, the primary ones include administration of **a)** Notice of Network Requirements and acknowledgement forms are presented to and signed by the employee for network acknowledgment; **b)** Educational sessions of the provider selection and network expectations to the employer and employee. An educational handbook can be used to demonstrate network ground-rules such as what happens if an employee treats out of the network, the responsibilities of the provider, who to contact in the network for customer service questions, etc.; and **c)** Identify areas that are critical to benchmarks, such as savings and enhancements in provider and employee relations.

13. What is the Quality Improvement Program (QIP) in a network?

A Quality Improvement Program (QIP) is an annual program that incorporates a work plan, measures Case Management and return to work, and other areas of an internal network that provide benchmarks on results, patterns and performance. The law requires that every network have a QIP.

14. How does a network manage a complaint?

The network manages a complaint through a detailed process of acknowledgement. Every network must have an internal complaint process that meets the criteria of TDI.

15. How does the network get a provider out of the network when the provider's performance is not good?

A network must have a protocol in place that reviews performance and expectations of a provider. Should the contract or performance not be met through verbal and written warnings, a process should be in place to screen out those not meeting network expectations.