

Provider Manual
Prime Comp Network

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Introduction

Prime Comp Network is a provider network for Workers' Compensation injury treatment. This select medical provider panel was developed to provide quality medical care while controlling employers' costs. Prime Comp Network includes providers who understand Workers' Compensation and treatment of occupational injuries which enables the injured worker to promptly return to a more productive life. Prime Comp Network contracts with payers and self-insured employers who want the best medical care while maintaining effective cost control. Being a member of a progressive integrated delivery system for Workers' Compensation injury treatment allows the providers to work together to ensure quality medical care, in cooperation with the other dedicated professionals.

Each injured employee may receive medical treatment for a specific injury by selecting a Primary Care Provider (PCP) from the most current provider directory available through their employer. The injured employee receives all initial covered services from the Primary Care Provider, excluding emergency care. During the course of treatment all care is provided by the Primary Care Provider/Medical Care Coordinator (PCP/MCC), except when the PCP/MCC makes a referral to a specialist.

The two primary objectives of Prime Comp Network are:

- 1) To ensure the provision of optimum, necessary and appropriate medical care, therefore achieving the goal of reducing the length of employee impairment.
- 2) To facilitate the timely return-to-work program by coordinating activities with medical providers, injured workers, employers and care managers

It is the goal of Prime Comp Network to ensure that each employee with a work-related injury or illness receives prompt and appropriate health care services. Our medical professionals are selected based upon a dedication to providing quality care, which leads to a prompt return to maximum medical improvement.

Please take the time to review the information and materials contained in this manual. If you have any questions, or if we can assist you in any way, please do not hesitate to contact a Provider Relations Representative at (904) 376-3790. Welcome to Prime Comp Network! We look forward to working with you.

Glossary of Terms and Definitions

Agency: The Agency for Health Care Administration (ACHA)

Alternate Medical Care: A change in treatment or health care provider

Appeal: A further request to reverse a denied grievance or denied treatment plan.

Carrier: An insurance carrier, self-insurance fund or individually self-insured employer, or assessable mutual insurer.

Case Manager: An individual specially trained to assist the MCC in evaluating and implementing an approved treatment plan.

Catastrophic Injury: A permanent impairment constituted by:

1. Spinal cord injury involving severe paralysis of an arm, a leg, or the trunk;
2. Amputation of an arm, a hand, a foot, or a leg involving the effective loss of use of that appendage;
3. Severe brain or closed-head injury as evidenced by:
 - a. Sensory or motor disturbances;
 - b. Severe communication disturbances;
 - c. Severe complex integrated disturbances of cerebral function;
 - d. Severe episodic neurological disorders; or
Other severe brain and closed-head injury conditions.
4. Second-degree or third-degree burns of 25 percent or more of the total body surface or third-degree burns of 5 percent or more to the face and hands;
5. Total or industrial blindness; or
6. Any other injury that would otherwise qualify under this chapter of a nature and severity that would qualify an employee to receive disability income benefits under Title II or supplemental security income benefits under Title XVI of the federal Social Security Act as the Social Security Act existed as of July, 1 1992, without regard to any time limitations provided under that act.

Certified Health Care Provider: A health care provider who has been certified by the Division of Workers' Compensation or who has entered an agreement with a licensed managed care organization to provide treatment to injured workers.

Compensable: A determination by a carrier or judge of compensation claims that a condition suffered by an employee results from an injury arising out of and in the course of employment.

Complaint: Any dissatisfaction concerning medical issues and/or employees' rights and can be originated by a personal or telephone contact.

Disability: Incapacity, because of an injury, to earn in the same or any other employment the wages, which the employee was receiving at the time of the injury.

Emergency: The sudden and unexpected onset of a condition that requires medical care or treatment, including but not limited to hospital service, that could result in the risk of loss of life or permanent damage to the employee's health if he/she did not receive immediate medical attention.

First Report of Injury (DWC-1): The document an employer is required to complete in the event of an on the job injury by an employee. Commonly referred to as the ANotice of Injury.≡

Health Care Facility: Any hospital licensed under Florida Statutes, Chapter 395 and any health care institute licensed under Florida Statutes, Chapter 400.

Indemnity Payment: Payment made to the injured worker based upon the type of injury and their average weekly wage.

Independent Medical Examination (IME): An objective medical or chiropractic evaluation of the medical condition of an injured employee with a work-related injury and work status performed by a physician other than the treating physician.

Independent Medical Examiner: A physician selected by either an employer or a carrier to render one or more independent medical examination in connection with a dispute under Florida Statutes, Chapter 440.

Injury: Personal injury or death by accident arising out of and in the course of employment, and such diseases or infections naturally or unavoidably result from such injury.

Insurer: An insurance carrier, self-insured fund, assessable mutual insurer, or individually self-insured employer.

Maximum Medical Improvement (MMI): The date after which further recovery from, or lasting improvement to, an injury or disease can no longer reasonably be anticipated, based upon reasonable medical probability.

Managed Care Arrangement (MCA): An arrangement under which a provider of health care, a health care facility, a group of providers of health care, a group of providers of health care and health care facilities, an insurer that has an exclusive provider organization approved under s. 627.6472 or a health maintenance organization licensed under Part I of Chapter 641 has entered into a written agreement directly or indirectly with an insurer to provide and to manage appropriate remedial treatment, care, and attendance to injured workers in accordance with this chapter.

Medical Care Coordinator (MCC): A Primary Care Provider within a provider network who is responsible for managing the medical care of an injured worker, including determining other health care providers and health care facilities to which the injured employee will be referred for evaluation or treatment. A MCC shall be a Physician licensed under chapter 458 or chapter 459, a chiropractic physician licensed under chapter 460, or a podiatric physician licensed under chapter 461.

Medically Necessary or "Medical Necessity": Any medical service or medical supply which is used to identify or treat an illness or injury, is appropriate to the patient's diagnosis and status of recovery, and is consistent with the location of service, the level of care provided, and applicable practice parameters. The service should be widely accepted among practicing health care providers, based on scientific criteria, and determined to be reasonably safe. The service must not be of an experimental, investigative, or research nature.

Modification: Adapting the pre-injury job to comply with an injured worker=s current physical abilities when the injured worker cannot return to the pre-injury job due to physical limitations from the injury.

Permanent Impairment: Any anatomic or functional abnormality or loss determined as a percentage of the body as a whole existing after the date of Maximum Medical Improvement, which results from the injury.

Provider Network: A comprehensive panel of health care providers and health care facilities who have contracted directly or indirectly with an insurer to provide appropriate remedial treatment, care, and attendance to injured workers in accordance with the Florida Statutes 440.

Request for services: Initial requests for services, such as a request for medical services, second opinions, or a change in providers, are not considered a complaint or grievance.

Service Area: The agency approved geographic area within which an insurer is authorized to offer a Workers= Compensation Managed Care Arrangement.

Specialist Provider: A Physician or provider who is licensed by the State of Florida and one who has agreed to provide covered specialty services.

Transitional Work: Any job within the organization adapted to comply with the injured worker=s current physical abilities when the injured worker cannot return to his pre-injury job due to physical limitations from the injury. Transitional work allows changes to the job duties as the employee recovers and gains functionality. A specific time limit may apply to transitional work.

Utilization Review: The evaluation of the appropriateness of both the level and the quality of health care and health care services provided to the employee with a work-related injury or illness.

Waiting Period: The time period between the date of accident and the initiation of indemnity benefits. In the State of Florida, periods of disability up to seven (7) days do not result in payment of indemnity benefits. On day eight (8), the injured worker becomes eligible for benefits. If the worker is disabled from work for greater than twenty-one (21) days, compensation will be allowed from the date of the disability.

Workers= Compensation Managed Care Arrangement (WCMCA): An arrangement under which a provider of health care, a health care facility, a group of providers of health care and facilities, an insurer that has an exclusive provider organization approved under s.627.6472 or as a health maintenance organization licensed under Part I of chapter 641 has entered into a written agreement directly or indirectly with an insurer to provide and to manage appropriate remedial treatment, care, and attendance to injured workers.

Written Grievance: It is a signed grievance, utilizing AHCA Grievance Form No. 3160-0019, from the injured employee, provider, or their designated representative to the insurer or delegated entity. The injured employee or provider is not required to make a complaint prior to filing a written grievance.

Overview of Florida Managed Care Law

In 1993, the Florida legislature began to introduce managed care within the Workers= Compensation system. The objectives of the law were three fold:

1. To provide access to quality medical care.
2. To improve return-to-work outcomes.
3. To thereby reduce indemnity (lost wage payout) and medical costs.

Effective January 1, 1997 all medical care associated with a Workers= Compensation injury had to be provided through a certified Managed Care Arrangement (MCA). Effective October 1, 2001 MCA's are not mandatory. Every Workers= Compensation Managed Care Arrangement (WCMCA) must consist of:

- X A network of medical providers which covers a broad variety of specialties and services to ensure accessibility to care for injured workers;
- X An employee education program;
- X A mechanism to allow injured workers to appeal decisions within the Managed Care Arrangement;
- X A Quality Assurance program which assures that the health care services provided to injured workers meet quality care standards which are consistent with the prevailing standards of medical practice in the community;
- X Aggressive Medical Care Coordination services to facilitate timely recovery from injury and return-to-work;
- X A mechanism for peer review of provider treatment plans;
- X Utilization Review services which include pre-certification review;
- X A grievance process for injured workers to appeal treatment and managed care decisions;
- X Appropriately documented medical records;
- X Primary Care Provider (PCP) – a Physician who may be a family practitioner, general practitioner, internist, chiropractor, podiatrist, or dentist who renders initial and ongoing care; and
- X Medical Care Coordinator (MCC) – a Primary Care Provider who is responsible for managing the medical care of the injured worker and is a licensed Physician under chapter 458 or an osteopath licensed under chapter 459; chiropractic physician licensed under chapter 460; or a podiatric physician licensed under chapter 461.

Workers= Compensation Coverage

Scope of Coverage: The Florida Workers= Compensation law provides coverage for the provision of health care services for employees with work-related injuries, occupational diseases, or illnesses arising out of, and in the course of employment. There are no deductibles, coinsurance percentages, or aggregate limits. However, employees who do not use participating providers may be required to pay all or a portion of their medical expenses.

Co-Payment: There are no co-payments with the exception of when an employee reaches Maximum Medical Improvement (MMI). Should an employee with a work-related injury or illness reach overall Maximum Medical Improvement and desire further medical treatment, the employee will be responsible for a \$10 co-payment per visit.

Eligibility for Benefits: All employees with a work-related injury or illness are entitled to necessary medical care. In the event the employee loses time from work because of the related injury or illness the employee may receive compensation for time missed in excess of seven days. The employee receives no compensation for the first seven days unless more than twenty-one days are missed at which time payment may be authorized from the date of injury or illness.

Impairment Income Benefits: Entitlement is based upon the impairment rating established by the provider and begins on the day after the employee with a work-related injury or illness reaches Maximum Medical Improvement (MMI) or at the expiration of temporary benefits, whichever occurs first.

Supplemental Benefits: Provides supplemental benefits, to be paid to the employee with a work-related injury or illness, with an impairment rating of 20% or more, who has not returned to work, or has returned to work earning less than 80% of the average weekly wage as a direct result of the employee=s impairment, and has attempted to obtain employment.

Reasons for Denial: Listed below are examples of but not limited to, circumstances which may create disputes of payor responsibility:

1. When an injury is occasioned primarily by the intoxication of the employee; by the influence of any drugs, barbiturates, or other stimulants not prescribed by a Physician; or by the willful intention of the employee to injure or kill himself, herself, or another.
2. If the injury is caused by the employee=s deliberate disregard of safety and or willful misconduct.
3. If the employee claims to have been injured on the job, but investigation reveals that his/her condition is unrelated to his/her employment.
4. When the accident is not the major contributing cause of the condition symptoms.
5. The accident or injury did not arise out of or in the course of employment.

Benefits under Workers= Compensation Coverage

Compensability and Coverage

When an employee files a claim for Workers= Compensation benefits, two areas need to be researched before the carrier or third party administrator pays the claim – **compensability and coverage**. If the claim is being handled by an insurance carrier and is based upon an insurance contract, verification that the employer has a Workers= Compensation policy in place at the time of the accident is necessary.

Compensability is the determination of whether the claim arose out of and in the course of employment. Workers= Compensation is only bound to pay for claims which occurred because of an on the job injury. Workers= Compensation is paid without regard to fault as a cause of injury. A worker loses his/her rights to compensation if his/her injury is solely due to intoxication or from a willful intention to injure himself/herself or to injure others.

Workers= Compensation is an exclusive remedy for the employee as it relates to their industrial injury except in some third party personal injury cases. Exclusive remedy means that the injured individual gives up the right to sue the employer for damages for the advantage of the no-fault nature of Workers= Compensation, i.e. the injured worker does not need to sue the employer as benefits are set by statute once a claim is determined to be compensable.

Benefit Coverage

Under the Florida Workers= Compensation Law, benefits are determined by the rate of wages an employee receives, the period of disability, and the nature of the injury. There are two categories of benefits an injured worker may receive, **medical and indemnity**.

Medical includes all necessary remedial treatment, care and attendance for such period as the injury or process of recovery and return-to-work may require. This must include pharmaceuticals, medical supplies, durable medical equipment and other medically necessary services. Medical care does not require a seven (7) day waiting period. There are no deductibles or co-payments with the exception of when an employee reaches Maximum Medical Improvement (MMI). The employer is responsible for all medical payments related to the compensable injury.

Indemnity benefits are the wage replacements an injured worker receives when unable to work. Indemnity benefits are subject to a seven (7) day waiting period. In the State of Florida, the injured worker must have missed seven work days in order to receive these benefits. Once this threshold has been met and as long as the injured worker is disabled or until limits are met, the worker will receive an indemnity payment every two weeks. The rate of payment is based upon the classification of disability as well as the employee's base salary prior to the injury.

In the case that an injured worker does not miss time from work but is receiving medical treatment the term "medical only" is used. When the injured worker is unable to work for seven (7) days, the claim is referred to as a "lost time claim".

Relatedness to the Compensable Injury

The employer is only responsible for medical conditions that are directly related to the compensable injury. A pre-existing injury or condition that occurred post accident that was not brought about by the compensable injury and is not related to the industrial injury will not be covered under Workers= Compensation. It is the responsibility of the treating provider to identify any pre-existing or unrelated

condition as soon as it becomes known and to outline the impact that condition may have on the employees medical recovery and return-to-work.

Medically Necessary Care

As a provider with Prime Comp Network your responsibilities are to provide timely care that is medically necessary and appropriate. Medically necessary as defined in the Florida Statute 440.13 (1)(1) means:

Any medical services or medical supply which is used to identify or treat an illness or injury, is appropriate to the patient's diagnosis and status of recovery, and is consistent with the location of service, the level of care provided, and applicable practice parameters. The service should be widely accepted among practicing health providers, based on scientific criteria, and determined to be reasonably safe. The service must not be of an experimental, investigative, or research nature."

Timely Communication

As a member of Prime Comp Network you should provide timely communication regarding the injured worker's physical condition, treatment plan, and ability to return-to-work. This information should be conveyed to the claims adjuster or their Case Manager immediately upon any change in the injured worker's status.

Emergency Care

In an emergency situation, care must be rendered. Notify the claims adjuster or Case Manager as soon as possible regarding the care rendered and events leading up to the emergency situation.

If an emergency admission to the hospital is necessary, the claims adjuster or Case Manager must be contacted within 24 hours of the admission.

Disability Classification

Workers' Compensation is paid based on the following four types of disability:

1. Temporary Total Disability
2. Temporary Partial Disability
3. Permanent Partial Disability
4. Permanent Total Disability

Temporary Total Disability (TTD)

A disability that completely prevents an injured worker from returning to work for a limited period of time. Temporary total disability may become permanent total or permanent partial disability dependent upon the medical outcome of the case. During this time period, the injured worker is not able to perform any work activities; the employee is totally disabled from work.

Many of the cases that you will see fall into this category. Based upon each individual employee, their sustained injury and the type of work performed, a TTD is subject to reclassification as the injured worker's condition improves and changes.

Temporary Partial Disability (TPD)

An injury or illness which prevents the worker from performing at full capacity for a temporary period of time. A partial disability is one which impairs the earning capacity but does not involve total disability to work.

TPD is by definition temporary and considered subject to change. Often a worker is reclassified from TTD to TPD as their medical condition improves.

Permanent Partial Disability (PPD)

An injured worker is classified as PPD when they have sustained an injury which is permanent but allows for the worker to return to work with some loss of function. PPD may result from amputation of a limb, in part or whole, or through the inability to use that body part to its fullest ability.

As defined in Florida Statutes, Chapter 446, a permanent impairment is determined once the worker has reached Maximum Medical Improvement and impairment benefits are due and payable within 20 days after the carrier has knowledge of the impairment.

Permanent Total Disability (PTD)

This classification is the most extreme type of disability and is defined in the Florida Statutes as a catastrophic injury whereas the injured worker is unable to return to work in any capacity. Only injured workers with catastrophic injuries are eligible for permanent total benefits. In no other case may permanent total benefits be awarded.

Return to Work Coordination

One of the goals of the Workers= Compensation managed care program is to facilitate timely and appropriate return-to-work. Effective coordination of return-to-work efforts requires teamwork from the injured worker, medical provider(s), the employer, and the Case Manager. Each one of the entities has certain responsibilities or roles to play as a team member. The following outlines these responsibilities:

The Medical Provider:

1. Identify physical abilities,
2. Provide a release to return-to-work as soon as appropriate.

The Injured Worker:

1. Accurately portray the physical demands of the job held at time of accident
2. Attempt return-to-work when released by a medical provider.

The Case Manager:

1. Communicate physical demands of any jobs available to the medical provider and injured worker,
2. Work with the employer to develop modified duty alternatives that match the limitations of the injured worker,
3. Develop phased in return-to-work plan when necessary.

The Employer:

1. Provide an accurate description of employee=s job and any modified duty assignment,
2. Abide by restrictions as stated by medical provider,
3. Develop modified duty alternatives when ever possible.

The injured worker can be returned to work dependent upon the unique circumstances associated with their medical recovery, limitations, and jobs available at the employer. The following details the types of releases to return-to-work:

outlined by the provider, find a job that matches the restrictions, or create a job that will allow the employee to return to work.

Often the Case Manager will make a copy of a job description available to the Provider that outlines the physical demands of a potential job. When the provider receives a job description, they should compare the physical demands listed with their opinion regarding the injured worker's ability to perform those functions. If the provider does not feel that the injured worker can perform all the physical demands, indicate clearly what should be changed in order to allow the worker to return to work. Do not rule out the entire job if there are only a few exceptions. If the provider shares any concerns with the Case Manager, they can discuss with the employer any possible modifications to the position to meet the provider's restrictions.

It is good practice to discuss the restrictions and release of such restrictions with the injured worker. This provides the opportunity for the injured worker to address any concerns that they may have and allows the provider to explain what the recommendations are based upon. Sometimes the injured worker may indicate that they are not ready to return to work despite the provider's opinion. The provider will have to assess each case individually. However, if the provider feels it is appropriate for the injured worker to attempt to return to work, the provider should inform the worker that his/her recommendation would stand.

If the injured worker's medical condition changes, the provider will reassess this decision. If there are any doubts about a full duty release to return to work or an 8 hour day, do not hesitate to phase in the return-to-work. The Case Manager will work with the provider, injured worker, and the employer to develop a strategy to get the worker back on a regular schedule as soon as their condition allows.

Claim Submission Procedures

When you have provided services, you must submit a bill with all supporting documentation and reports to receive payment for the services provided. Please refer to the Prime Comp Network Payor Sheet for claim submission addresses. All claims are to be sent directly to the claims payor, unless noted differently for a specific Employer.

Claims for solo practitioners, group practice providers, clinics, and hospital-owned clinics, must be submitted on a CMS-1500 (DWC-9) form. Hospitals must submit claim(s) on a UB-04 (DWC-90) form. Only medical expenses for work-related injuries or illness are to be billed to the Workers' Compensation claims payor. You must include the following information:

- X Name, Age, Sex, Address, and Social Security Number of the employee;
- X Employer's name and address;
- X ICD-9 Diagnostic Code(s)
- X CPT-4 procedure Code
- X Your normal charge(s) by CPT-4 Code
- X Name, address, signature, and Tax ID of Physician providing service
- X Date of service
- X Procedure description

Submit all claims with your full fee amount and the appropriate codes and information. Do not discount fees prior to claim submission for completeness and accuracy prior to submission. Acceptance of contractual amounts as payment in full is required to comply with state law.

When you receive your remittance payment, there will be an Explanation of Benefits (EOB) form accompanying the check. It will include the following:

- X Name and Social Security Number of employee
- X Date(s) of service

- X Total charges submitted
- X Allowed amount
- X Non-covered service
- X Amount paid

If you have any questions or concerns regarding a claim, contact the payor at the number indicated on the Explanation of Benefits (EOB) or refer to the Prime Comp Network Payor Sheet for the claims handling entity.

The Physician's Role in Managed Care

Workers= Compensation is intended to provide only those medical and disability benefits needed to support the injured worker through the healing and return-to-work processes. The desired outcome is to minimize the disability period and permanent impairment by providing prompt medically necessary services which will restore the injured worker as close as possible to pre-injury status. It is the responsibility of every authorized health care provider in the Workers= Compensation program to contribute to this outcome without jeopardizing medical care.

The Physician, from the onset of treatment, must reinforce the return-to-work goal in communication with both the injured worker and the employer. Both parties realize that their long-term interests are best served by maintaining the employment relationship. At the time the Physician submits the Uniform Medical Treatment/Status Report Form (Form DWC-25), the current work status of the injured worker must be provided to the carrier based on any medical restrictions the Physician identifies. The Physician should not hesitate to ask for, nor should an employer hesitate to provide, the written job description which specifies the essential functions of the job, as well as the physical and environmental requirements to which the injured worker must return.

Except in an emergency the Physician must obtain authorization from the employer=s insurance carrier (or from the employer, if self-insured), in order to render care to an injured employee.

The Florida Managed Care Law specifies three types of providers within the Managed Care Program:

Medical Care Coordinator (MCC): Is a provider within the network who is responsible for managing the medical care of an injured worker including determining other health care providers and health care facilities to which the injured worker will be referred for evaluation or treatment. A MCC shall be a Physician licensed under chapter 458, an osteopath licensed under chapter 459, a chiropractor licensed under Chapter 460, or a podiatrist licensed under Chapter 461. The MCC is the primary clinical leader in the coordination of the injured workers= medical care and is responsible for managing and/or treating the injured worker from the date of injury until the date of release from medical treatment. The MCC may also be the injured worker's Primary Care Provider.

Primary Care Provider (PCP): Is usually the initial treating provider, except in the case of emergency treatment. The PCP typically continues to treat the injured worker and may be a family practitioner, general practitioner, or internist Physician licensed under chapter 458; a family practitioner, general practitioner, or internist osteopath licensed under chapter 459; a chiropractor licensed under chapter 460; a podiatrist licensed under chapter 461; and optometrist licensed under chapter 463; or a dentist licensed under chapter 466.

Physician Specialists: Have been contracted by Prime Comp Network to provide specialty services to injured workers when referred by the MCC or Case Manager. All specialty care must be approved by the MCC.

Medical Provider Responsibilities

- Render health care services to injured workers which the provider is qualified to provide, which are medically necessary and consistent with the standard of quality care generally accepted in the provider=s respective medical community.
- The injured worker receives all initial covered services from the Primary Care Provider, except emergency care. The injured worker receives all continuing covered services from the Primary Care Provider, except when services from another provider are authorized by the MCC.
- Secure authorization for hospital admissions from MCC, Prime Comp or designee prior to the admission. Exercise best efforts to admit and/or refer to the Prime Comp Network panel of providers and hospitals. Utilize participating hospitals whenever possible, guided by the injured worker=s best medical interest.
- Exercise best efforts to see injured worker for initial injury treatment within two office hours. Exercise best efforts to see injured worker for follow-up or referral care within 48 hours of referral.
- Comply with procedures for authorization for treatment and referrals.
- Participate in Utilization Review programs and cooperate with Workers= Compensation related programs, such as return-to-work.
- Provide quality medical care to injured workers at reasonable costs, such as: expediting the reporting of treatments provided to injured workers.
- Participate in continuing education, quality assurance, pre-certification, and case management systems that are designed to provide needed treatment for injured workers.
- Comply with practice parameters and protocols supported by the United States Agency for Healthcare Research and Quality (AHRQ) for use with the Workers= Compensation Program.
- Upon request, provide to Prime Comp and third party payers contracting with Prime Comp, appropriate and complete information, records and other written documentation regarding health care services provided to injured workers.

Medical Care Coordinator Responsibilities

The Medical Care Coordinator (MCC) is responsible for managing the medical care of the injured worker. A medical provider may be the MCC as well as the Primary Care Provider.

- The injured worker must be referred to a Primary Care Provider within the network, except for emergency care, for all initial services.
- The MCC is responsible for referral to other providers within the network.
- The injured worker is allowed one change to an alternate provider during the course of treatment.
- The alternate provider must be within the same specialty and provider network.

- Referrals from the MCC will be made only to participating network providers. Exceptions to this include medically necessary treatment that is either unavailable in the geographic area or inaccessible by the injured worker in a geographic area.
- The MCC may be the Primary Care Provider. The MCC will be responsible for referring the injured worker to a specialist for care. The MCC will continue to monitor the injured worker's progress on a regular basis to assure they receive the most appropriate care, until the injured worker returns to full duty and is discharged at Maximum Medical Improvement.

Request for Alternate Medical Care

The injured worker is allowed one change of physician during the course of treatment for any one accident. If the injured worker requests a change of physician, the carrier shall authorize an alternative physician, within 5 days after receipt of the request, who shall not be professionally affiliated with the previous physician. Such requests must be reported to the Managed Care Arrangement.

Independent Medical Examinations: The employer and employee shall be entitled to only one independent medical examination per accident and not one independent medical examination per medical specialty. One if the parties agree, the examiner may be a health care provider treating or providing other care to the employee. The independent medical examiner may not provide follow-up care if such a recommendation for care is found to be medically necessary.

The party requesting and selecting the independent medical examination shall be responsible for all expenses associated with said examination, including, but not limited to, medically necessary diagnostic testing performed and physician or medical care provider fees for the evaluation. If the employee prevails in a medical dispute, the cost of such examination shall be paid by the employer or carrier. The exception is that if an employer is in a Managed Care Arrangement, the costs for the independent medical examination shall be paid by the carrier if such examination is performed by a physician in the provider network.

Identifying Maximum Medical Treatment

The provider identifies when the injured worker reaches Maximum Medical Improvement (MMI). MMI is reached when further recovery from or lasting improvements to, an injury or disease can no longer reasonably be anticipated based upon reasonable medical probability. If any permanent impairment exists, it should be documented immediately.

Once an injured worker has reached MMI, in order to continue treatment, the injured worker must obtain authorization from the Reviewing Company. The injured worker is then responsible for a \$10 per visit co-payment for on-going medical treatment. This co-payment applies only to dates of accident on or after January 1, 1994 and does not apply to emergency care. The co-payment is to be collected by the health care provider and will be deducted from the allowable fee billed to the carrier by the provider.

Authorizations

All treatment plans must be authorized in advance of delivery of care. Treatment plans may be conveyed to the claims payor's Case Manager or Utilization Review staff via fax communication or telephone contract. You will receive verbal approval or be advised that the Case Manager cannot approve the care requested. Written documentation will be forwarded to you. When the Case Manager cannot certify treatment requested you will be contacted by a Peer Reviewer. The Case Manager will make every effort to respond quickly to any requested in the interest of expediting medically necessary and appropriate care.

Please note that you will receive most authorizations from a Case Manager rather than from the employer or carrier. Please refer to the Prime Comp Payor Sheet for specific information regarding authorizations. Emergency care is excluded from the authorization requirement as long as notification to the claims payor or their Case Manager occurs within 24 hours of an admission or rendering treatment.

There will be no prepayment for any services provided to the injured worker prior to those services being rendered.

Medical Records Requirements

In order to comply with the Florida Statutes Section 440.134, the provider will submit the following information:

- DWC-25 Treatment/Status Report Form (required by the Division of Workers= Compensation) with work status and restrictions. **See page 17 for reporting schedule.**

A DWC-25 must be supplied to the carrier within three (3) days of initial treatment and at least every thirty (30) days thereafter. Failure to provide this information may result in fines by the Division of Workers= Compensation.

Documentation of Medical Necessity – when specifically requested, the provider must substantiate the medical necessity of services performed. When it is necessary to substantiate the medical necessity of services beyond the information contained in the medical record, the supporting documentation must be submitted in writing by the prescribing provider.

Practice Parameters – carrier must evaluate the appropriateness and over utilization of medical services provided to injured workers in accordance with medical practice parameters and protocols supported by the United States Agency for Healthcare Research and Quality (AHRQ) for use with the Workers= Compensation Program. You may view these currently endorsed practice parameters on the AHRQ website: www.guideline.gov/resources/guideline_index.aspx.

Documentation of Medical Status

All network providers are required to maintain a system which allows for prompt retrieval of legible and timely information which is accurately documented and readily available if requested by a health care practitioner with written authorization and consent from the patient. Your office procedures regarding medical records must protect the confidentiality of patient records.

The medical record must identify the patient as follows:

- X Name;
- X Identification number (usually claim and/or social security number);
- X Date of birth;
- X Employer;
- X Home and work telephone; and
- X Sex;

Include documentation of:

- X A summary of significant procedures;
- X Past and current diagnoses or problems; and
- X Allergies and reactions to current medications.

The medical records for each visit must indicate the following information:

- X Date;
- X Chief complaint or purpose of visit;
- X Objective findings of practitioner;

- X Diagnosis or medical impression;
- X Studies ordered, for example: lab, x-ray, EKG, and referral reports;
- X Therapies administered and prescribed;
- X Name and profession of practitioner rendering services, for example: MD, DO, DC, DPM, RN, OD, etc., including signature or initials of practitioner;
- X Disposition, recommendations, instruction to the patient and evidence of follow-up and the specific time of return (noted in weeks, months or as needed); and
- X Outcome of services.

Provider Procedures for Treatment

After a worker is injured, his/her employer will refer the worker to a Medical Care Coordinator (MCC) or Primary Care Provider (PCP). The designated Case Manager is available to assist with identifying a provider. In some instances an employee has been seen at an emergency room or has been discharged from the hospital and needs continued care. The employee will be referred through the Case Manager. The treating Physician (MCC/PCP) will be contacted prior to the referral to assure that he/she is aware of the case. There will be no prepayment for any services provided to the injured worker prior to those services being rendered. The Case Manager will arrange for the transfer of medical records.

The injured worker will identify and see a Prime Comp Network MCC/PCP for health treatment.

The treating Physician will refer to the Prime Comp Network Payor Sheet for authorization to evaluate the patient.

Once the injured worker has been evaluated and has received initial treatment, the treating Physician is required to **complete a DWC-25 form** and fax or mail the form, **within 3 days of initial treatment (and by the close of the next business day for follow-up visits)**, to the Case Manager specified on the Prime Comp Network Payor Sheet.

When appropriate, the Case Manager will phone the treating Physician to discuss the plan of treatment and return-to-work goals. If there are any questions concerning the proposed plan of treatment, the Case Manager=s Physician Advisor will contact the treating Physician to discuss the case.

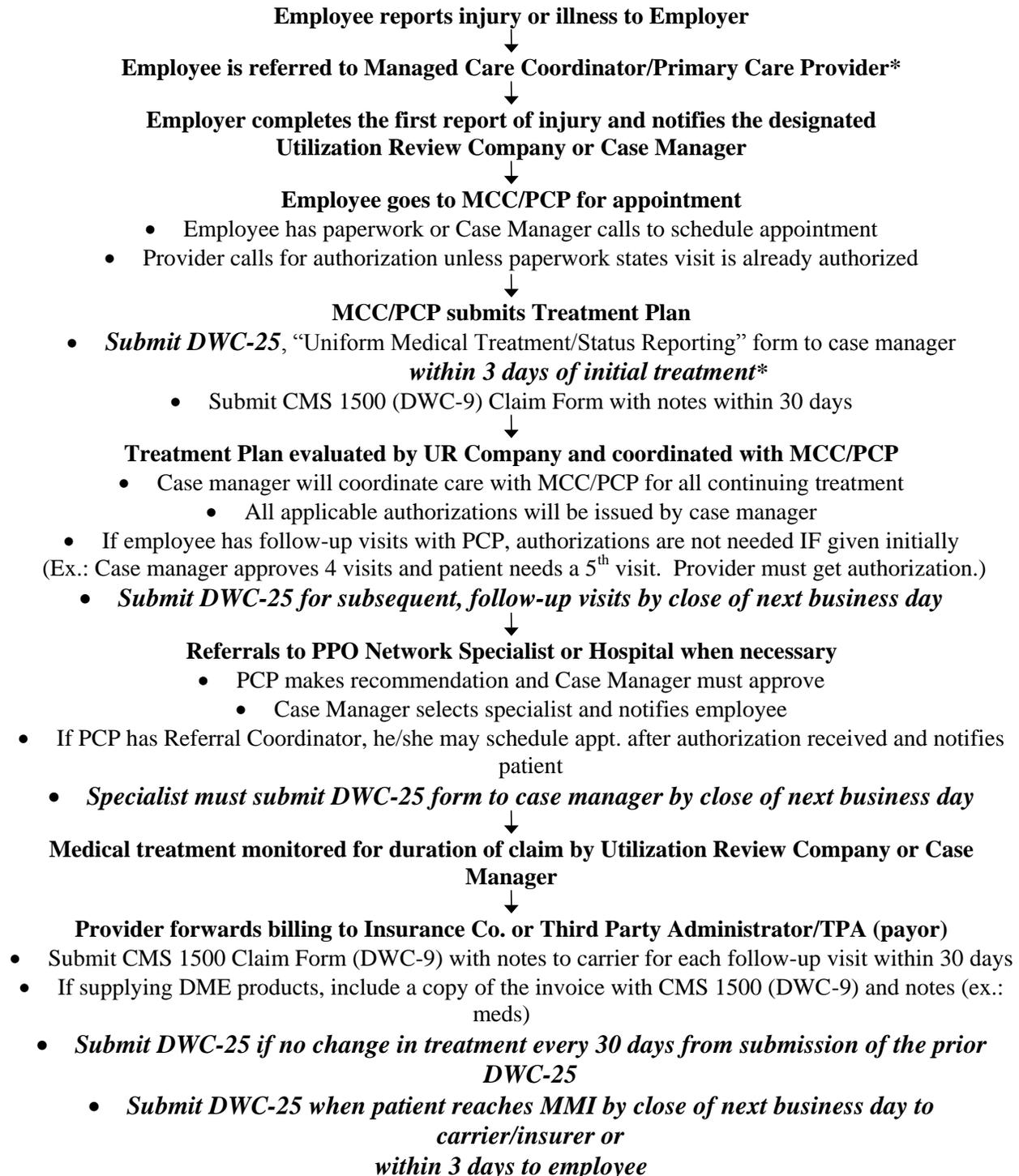
The treating Physician will initiate the plan of treatment, and discuss return-to-work goals with the injured worker. If a referral is indicated, the treating Physician will contact the Case Manager to discuss the referral recommendation and plan of treatment.

All referrals for specialist consultation and ancillary health services must be authorized and coordinated with the primary treating Physician (MCC/PCP) and the Case Manager. The treating Physician will coordinate with the employee and the Case Manager to ensure medical records are received by the specialist.

The Case Manager will review the referral request and if approved, will notify the specialist of authorization to render services as defined. The Case Manager will call the injured worker with instructions regarding any appointments.

Specialists are required to **complete a DWC-25 form** and fax or mail the form, **by the close of the next business day**, to the Case Manager specified on the Prime Comp Network Payor Sheet.

Coordination of Care Procedures



***EMERGENCY CARE:** In the case of an emergency that requires immediate medical care or treatment (there is a risk of loss of life or permanent damage to the injured worker), the employee should proceed to the nearest hospital or medical facility where he/she can be treated without authorization. **If Provider gives emergency care**, notify employer by close of 3rd business day after care is rendered. If employee is admitted, notify employer within 24 hours. Reimbursement will be given without authorization only in a true emergency situation

*Use Form **DWC-10** for Statement of Charges for Drugs and Medical Supplies

*Use Form **DWC-11** for Dental Claims

Provider Services

Prime Comp Network provider relations department is prepared to assist in ensuring that you, the provider, are satisfied with your participation in the MCA program. We are available to answer any questions concerning your participation in the MCA and we welcome your comments, suggestions, and communications.

In addition to your Provider Manual and Educational Packet, upon request, the provider relations specialist will conduct an office inservice to assist you and your staff in understanding Workers= Compensation and your participation in Prime Comp Network. You will also receive newsletters, faxes, and/or e-mails to keep you current on Workers' Comp information.

The Provider Relations Department can be contacted at (904) 376-3790.
Please notify Provider Relations as soon as possible of any changes in the following:

- X Tax ID Number
- X Office address(s)
- X Billing information
- X Telephone or Fax numbers
- X Group participation status
- X Resignation of a provider (e.g., retirement, death, move)
- X Addition of a provider

Notification Address:

Prime Comp Network
Provider Relations Department
P.O. Box 43115
Jacksonville, FL 32203

Provider Credentials

Prime Comp Network has adapted credentialing criteria that meets national standards in accordance with state and federal licensing regulations. In addition to initial credentialing, providers will be recredentialed every two years.

Accessibility & Available Service Standards

The following standards are applicable to all Prime Comp Network participating providers:

Emergency Care	Immediate
Initial injury	2 hours
Urgent Care	Within 24 hours
Waiting time – scheduled appointments	0 to 45 minutes
Specialist Appointment	Within 2 days
Lab Procedures	Within 72 hours
Radiology procedures	Within 72 hours
Physical Therapy	Within 5 days
Travel time to MCC or Acute Care	Max 30 minutes
Travel time to Specialist or Ancillary	Max 60 minutes
Reviewing Company response time	Within 24 hours

Network Provider Services response

Within 24 hours

PRIME COMP NETWORK INFORMATION

Who To Call:

Network Provider Questions XProcedural Questions XNetwork Services

Prime Comp Network

Provider Relations Representative

Ph: (904) 376-3790

Fax: (904) 391-5408

Authorization for Services

Reviewing Company/ Managed Care Authorization

Refer to the Prime Comp Employer Listing & Payor Sheet

Prepayment

There will be no prepayment for any services provided to the injured worker prior to those services being rendered.

Missed Appointments

Payers shall not pay for any missed or failed appointments.

Questions Regarding Specific Claims XClaim Submission Procedures

Third Party Administrator (TPA)/Claims Handling Entity

**refer to the Prime Comp Network Employer Listing & Payor Sheet

Patient Identification

- X Injured Worker should present to MCC/ PCP written or verbal authorization to obtain medical treatment.
- X Authorization form should identify the Reviewing Company (if it does not, refer to the Prime Comp Employer Listing & Payor Sheet).

MCC/PCP Provider Treatment Procedures

- X MCC/PCP will evaluate the patient and recommend plan of treatment to Reviewing Company (refer to Prime Comp Employer Listing & Payor Sheet for specified Reviewing Company)
- X MCC/PCP will fax or phone evaluation results to Reviewing Company within one (1) business day of evaluation

Reviewing Company Treatment Procedures

- X Reviewing Company will contact treating Physician (MCC/PCP) to discuss plan of treatment
- X MCC/PCP will initiate authorized plan of treatment
- X MCC/PCP will initiate return-to-work goals with injured worker
- X Reviewing Company will provide ongoing contact with treating Physician to discuss progress of injured worker

Specialist Referrals:

- X **Urgent Care:** MCC/PCP will fax or phone referral request to Reviewing Company within 24 hours
- X **Non-Urgent Care:** MCC/PCP will fax or phone referral request to Reviewing Company within 72 hours
- X Reviewing Company will notify MCC/PCP of approval or non-approval of referral request
- X Reviewing Company will notify injured worker of approval or non-approval of referral request
- X MMC/PCP will provide medical records with instructions for the Specialist
- X In the case of a non-approval of a referral request, the MCC/PCP and the Reviewing Company will develop an alternate treatment plan
- X Specialist provider will exercise best efforts to see injured worker for referral care within 48 hours of a referral.
- X Specialist provider will fax or phone evaluation results to Reviewing Company within one (1) business day of evaluation
- X Specialist provider will fax or mail evaluation results to MCC/PCP
- X Specialist provider and Reviewing Company will discuss recommendations and develop treatment plan

Note: In the event of an emergency with threat of loss of life or limb, injured worker should be directed to nearest medical service facility.

Maximum Medical Improvement (MMI)

Once the injured worker has reached overall Maximum Medical Improvement from an injury, all medical care rendered after the date of MMI requires an authorization from the Reviewing Company and co-payment from the employee on all non-emergency future medical visits. A co-payment of \$10 should be collected at the time of the visit.

MCC/PCP or Specialist is required to complete the DWC-25 form and fax or mail Reviewing Company, Carrier, and Employer by close of next business day when MMI is reached.

Permanent Impairment Rating

Refer to: Florida Impairment Rating Guide (FIRG)
Contact: Florida Workers= Compensation Institute (850) 425-8156

Claims Submission

Claims must be submitted on a CMS 1500 form that contains the appropriate CPT-4 and ICD-9 Codes. Refer to Prime Comp Employer Listing & Payor Sheet for information regarding where to submit claims. Do not discount fees prior to claim submission. Check claims for completeness and accuracy, as this will expedite the processing. Bill only medical expenses for work related injuries or illness to the Workers= Compensation Claims Payor.

Prime Comp Network adheres to Florida Statutes, Chapter 440, pertaining to Florida Workers= Compensation Laws.

Grievance Procedures for Managed Care Arrangements

The purpose of the grievance procedure is to provide each employee and provider with the procedure to resolve formal grievances. This grievance procedure shall be administered at no cost to the employee or health care provider.

Grievances:

1. A copy of the grievance procedure and forms for filing a written grievance shall be made available to providers, employees, or their designated representative within seven calendar days of receipt of request.
2. An employee or provider grievance is not considered to be a true grievance until either the insurer has received a signed grievance form from the employee or the provider grievance has been directed to the Grievance Coordinator. Initial requests for services, such as a request for medical services or a change in providers, are not considered a complaint or grievance. Any dissatisfaction concerning medical issues and/or employees' rights can be originated by a personal or telephone contact.
3. Grievances should be directed the appropriate Grievance Coordinator. Please refer to the appropriate Managed Care Arrangement to properly identify the Grievance Coordinator.
4. A specified phone number and address for the employee or provider to present a complaint shall be provided.
5. Upon receipt of a written grievance, the Grievance Coordinator shall gather and review medical and related information pertaining to the issues being grieved. The Grievance Coordinator shall consult with appropriate parties and shall render a determination on the grievance with 14 calendar days of receipt. If the determination is not in favor of the aggrieved party, the Grievance Coordinator shall notify the aggrieved party that the grievance is being forwarded to the Grievance Committee for further consideration unless withdrawn in writing by the employee or provider.
6. The Grievance Committee shall consist of not less than three individuals, of whom at least one must be a physician other than the injured employee's treating physician, who is licensed under Chapter 458 or 459, F.S., and has professional expertise relevant to the issue. The committee shall review the information pertaining to the issues being grieved and render a determination with 30 calendar days of receipt of the grievance by the committee unless mutually agreed to otherwise. If the grievance involves the collection of additional information from outside the service area, the insurer or delegated entity will have 14 additional calendar days to render a determination. The insurer or delegated entity shall notify the employee in writing within seven days of receipt of the grievance by the committee if additional information is required to complete the review of the grievance.
7. Grievance procedures are aimed at mutual agreement for settlement and may include arbitration procedures. A grievance, which is arbitrated pursuant to Chapter 682, Florida Statutes, is permitted additional time not to exceed 210 days from receipt of the written request for arbitration from the employee.
8. The Managed Care Arrangement shall provide written notice to the employees of the right to file a request for grievance validation with the Division of Workers' Compensation upon completion of the full grievance procedure or while the grievance is in arbitration. Request for validation shall be filed with the Division of Workers' Compensation.
9. Physician involvement in reviewing medically related grievances by the employee shall not be limited to the employee's PCP or MCC, but shall include at least one other Physician.

10. The Managed Care Arrangement shall offer to meet with the employee or provider at its administrative offices within the service area convenient to the employee or provider.
11. If a grievance is found to be valid, corrective action will be taken promptly.
12. All concerned parties will be notified of the results of the grievance.
13. The Managed Care Arrangement will maintain a record of each formal grievance, including:
 - a) a complete description of the grievance, the employee's or provider's name and address, the employee's health care provider's name and address, information relevant to the grievance and the Managed Care Arrangement name and address.
 - b) a complete description of the Managed Care Arrangement findings, conclusions, and final description of the grievance.
 - c) a statement as to the current level at which the grievance has been processed.
14. An annual report of all formal grievances filed by employees and provider shall be submitted to the appropriate agency, no later than March 31. The report shall list the number, nature, and resolution of all formal employee or provider grievances filed during the previous calendar year.

Quality Assurance Program

Prime Comp Network has created a network of medical professionals to enable Managed Care Arrangements for Workers' Compensation insurers in the State of Florida. In recognition of Prime Comp Network's responsibility to its clients, accounts, health care providers, professional staff and to the community it serves, Prime Comp Network's management and operations have adopted the Quality Assurance procedures described in this plan.

This Quality Assurance plan describes the program's objectives, organization, scope and mechanisms for overseeing the effectiveness of monitoring, evaluation, and problem solving activities that stress health and Return To Work (RTW) outcomes as the principal criteria for the evaluation of the quality of care rendered to injured workers.

Program Goal:

Provide a reference to objectively and systematically monitor and evaluate the quality and appropriateness of patient care rendered to injured workers, return to work outcomes and resolve identified problems.

Program Objectives:

- X Assure available resources and care are maintained at optimal, achievable levels of quality, and are delivered in an efficient safe manner.
- X Assure the provider network meets quality standards for patient safety, satisfaction, and return to work outcomes.
- X Encourage active participation of network providers in Workers' Compensation programs through education.
- X Assure health care practices and professional performance are valid and reliably evaluated.
- X Assure evaluation results are integrated appropriately in medical policies,

- procedures and operations with the objective of positive impact on patient care quality and return to work outcomes.
- X Provide a means for fulfilling and integrating the Quality Assurance responsibilities of all providers.
- X Provide a foundation for fulfillment of regulatory and statutory standards.
- X Evaluate, modify, and enhance the Quality Assurance Program to improve its effectiveness.

Scope of Program:

To accomplish these objectives, the QA Program is designed to:

- X Identify services, practices, professional performance, and patient outcomes, i.e. in terms of impact on quality of care and RTW.
- X Collect and analyze patient care service, provider practice, performance, and RTW outcome data so that patterns are ascertained.
- X Evaluate these patterns of practices, performances, and outcomes for their relative impact on the quality of care, efficient resource utilization, patient safety, and RTW results.
- X Establish priorities for effecting change.
- X Effect change so that problems are overcome or reduced, in accordance with the priorities established.
- X Demonstrate annually that the QA program's objectives are being attained.

Process Overview:

Quality Assurance provides a means of systematic health care evaluation to ensure excellence in health care delivery and outcomes. Two major components of Quality Assessment involve:

1. Securing measurements/standards and determining the degree to which standards are not met.
2. Introducing changes based on the information supplied by the measurement with the aim toward improvement.

Quality Assurance activities indicate when performance measurement varies in relation to standards of practice. Quality Assurance processes focus on the following activities:

- X Quality Improvement
- X Physician Credentialing
- X Employee Rights and Responsibilities
- X Employee/Provider Satisfaction Surveys
- X Preventive Health and Early Return to Work Services
- X Medical Records Reviews

Procedures for corrective action must address the process changes as an ongoing way of health care delivery rather than a one-time action. Procedure for implementing a corrective action is as follows:

- X Identification of a problem
- X Analysis of quality data that generates a realistic and cost effective corrective action plan
- X Implementation of the corrective action plan
- X Monitoring of progress to ensure that the problem is corrected

Quality Assurance activities shall focus on known problems and areas with potential for significant improvements in the case of professional practice. The Quality Assurance activities shall encompass the following three functions:

1. **Information Gathering:** The Medical and Operation Director(s) will design, use, and supervise:
 - X the use of systematic information gathering procedures, QA studies, projects, and tracking issues
 - X methods for aggregating the information gathered formats for displaying and reporting the information for assessment and analysis
 - X systems for maintaining and storing all relevant information to ensure resolution and documented evidence of quality improvement

2. **Assessment and Analysis:** The functions of assessment and analysis are generally based on statistical measurements of performance generated by staff, network providers, and the QA committee. The data and information are analyzed by appropriate peer groups. The QA committee develops and provides professional direction to the information gathering assessment/analysis of data and recommendations. Aspects of quality care reviewed in this process may include:
 - X Access to care
 - X Appropriateness
 - X Efficiency
 - X Technical outcome of care
 - X Member satisfaction with services provided

3. **Corrective Action and Follow-Up:** Corrective actions should concentrate on making improvements. Each problem must be tracked so that appropriate corrective actions are taken. Corrective actions may include:
 - X Verbal consultation
 - X Written consultation
 - X Termination

Quality Assurance Program Organizational Structure:

The QA Plan involves the providers, administration and staff. The implementation of this plan is the responsibility of the QA Committee. The following identifies Prime Comp Network's QA Committee potential membership:

- X Prime Comp Program Director
- X Prime Comp Operations Staff
- X Prime Comp Provider Relations Staff
- X Medical Director
- X Network Providers

Tracking/Reporting Quality Assurance Information:

Tracking of Quality Assurance issues is a problem focused methodology that identifies practice patterns and performance measurements for health care delivery. Tracking medical care and RTW issues is a problem focused methodology that identifies health care delivery. Tracking objectives include:

- X The use of data collected in a standardized manner from medical records/chart review, administrative (or transaction) data and customer satisfaction surveys
- X The provisions for integrating information
- X The implementation and documentation of corrective actions which address over and under utilization, questionable expenditures, quality, accessibility, availability and continuity of care.

The Medical Director and/or operations director will be responsible for the following:

- X Advising on specific data and data processing support programs required for monitoring and evaluating activities
- X Designing tracking guidelines, standardized data gathering, display, and inter-communication systems to manage and control all data and maintain confidentiality
- X Preparing reports and compiling findings for analysis by the QA Committee
- X Gathering of data required to monitor compliance with corrective action
- X Preparing the annual review report and minutes of the Quality Assurance Program
- X Maintaining appropriate documentation of Quality Assurance activities, including cumulative profiles of findings, i.e. provider data, appeals, sanctions, and grievances

Program Evaluation:

The Quality Assurance Committee evaluates the effectiveness of the QA Program annually. The evaluation process takes into account the:

- X Resources expended in carrying out program activities
- X Quantitative evidence of substantive impact
- X Measures of the value of various program activities in relation to their cost

Confidentiality

Prime Comp Network will maintain written policies and procedures that reflect its commitment to respect the privacy of the providers. Access to provider information will be used only to carry out the duties of Prime Comp Network, and will be limited to only those employees who need the information in order to perform their duties. Appropriate actions will be taken to protect against unauthorized or inadvertent disclosure of confidential information.

Credentialing representatives shall keep in strict confidence all papers, reports, and information obtained by virtue of their responsibility of credentialing activities. Confidential written records will be kept in a

secure manner. Information gathered in conjunction with credentialing activities will not be released outside Prime Comp Network, except as requested by law, and as authorized by the Medical Director and Director.