



BUREAU OF MANAGED HEALTH CARE
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INTERPRETIVE GUIDELINES
WORKERS' COMPENSATION
MANAGED CARE ARRANGEMENTS

8/19/02

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Note: Statute and rule in the interpretive guidelines are included for informational purposes. Florida Statute and Administrative Code should be referenced for the complete text.

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STANDARD	INTERPRETIVE GUIDELINES
<p><u>WC 1</u></p> <p><u>QUALITY ASSURANCE –QA PROGRAM</u></p> <p>The insurer or delegated entity shall have a <u>description</u> of the <u>quality assurance program</u> which assures that the health care services provided to workers shall be rendered under reasonable standards of quality of care consistent with the <u>prevailing standards</u> of medical practice in the medical community.</p> <p>The program shall include, but not be limited to:</p> <p>(A) A <u>written statement of goals and objectives</u> that stresses health and <u>return-to-work outcomes</u> as the <u>principal criteria</u> for the evaluation of the quality of care rendered to injured workers.</p> <p>(B) A <u>written statement describing how methodology has been incorporated into an ongoing system for monitoring of care</u> that is individual case oriented and, when implemented, can provide interpretation and analysis of patterns of care rendered to individual patients by individual providers.</p> <p>s. 440.134(6)(c) 1, 2, F.S.</p>	<p>The insurer or delegated entity shall include in the description of the quality assurance program, but not be limited to:</p> <ol style="list-style-type: none"> 1) A written statement of <u>goals and objectives</u> that stresses <u>health</u> and <u>return-to-work outcomes</u> as the <u>principal criteria</u> for the evaluation of the quality of care rendered to injured workers; and 2) A written statement describing how <u>methodology</u> has been incorporated into an ongoing system for: <ol style="list-style-type: none"> a) Monitoring of individual care b) Interpretation and analysis patterns of care rendered to individual injured employees by individual providers.
<p><u>WC 2</u></p> <p><u>QUALITY ASSURANCE –QA PROGRAM</u></p> <p>Each insurer or delegated entity shall have an ongoing <u>quality assurance program</u> designed to objectively and systematically monitor and evaluate the quality of patient care, based upon the prevailing standards of medical practice in the community.</p> <p>59A-23.004(1), F.A.C.</p>	<p>The insurer or delegated entity shall have an ongoing quality assurance program to evaluate and monitor the medical care provided to injured workers, and to resolve identified problems. The program shall identify:</p> <ol style="list-style-type: none"> 1) The scope of the quality assurance program (See Tag WC3); 2) The role, structure and function of the quality assurance committee and other associated committees, including reporting relationships between committees (See Tag WC6); 3) Lines of authority and accountability; including oversight of delegated entities; 4) An annual work plan (See Tag WC4); 5) Methodologies for monitoring and evaluating quality of care; and 6) Methodologies for tracking and trending patterns of care and procedures for resolving identified problems.

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	<p>The insurer or delegated entity shall have a written policy and procedure and implement the quality assurance process.</p>
<p><u>WC 3</u></p> <p><u>QUALITY ASSURANCE – SCOPE</u></p> <p>The <u>scope</u> of the <u>quality assurance program</u> shall include the following:</p> <ul style="list-style-type: none"> (A) Peer review; (B) Satisfaction survey; (C) Utilization management; (D) Case management; (E) Complaints and grievances; (F) Credentialing and recredentialing; (G) Medical records; (H) Return to work; (I) Cost analysis; (J) Data collection; (K) Outcome studies; (L) Education; and (M) Provider dispute resolution. <p>59A-23.004(2), F.A.C.</p>	<p>The insurer or delegated entity shall have a policy and procedure, which outlines the <u>scope</u> of the quality assurance program. The scope shall include the components listed in column 1.</p> <p>Individual components will be addressed under separate tags.</p>
<p><u>WC 4</u></p> <p><u>QUALITY ASSURANCE – ANNUAL PLAN</u></p> <p>The <u>quality assurance plan</u> shall be in <u>writing</u>, updated <u>annually</u>, and shall describe the <u>program's objectives, organization and problem-solving activities</u> for improvement of medical services.</p> <p>The plan shall specify:</p> <ul style="list-style-type: none"> (A) Those specific activities under the ongoing <u>quality assurance program</u> designed to objectively and systematically monitor and evaluate the quality of patient care, based upon the prevailing standards of medical practice in the 	<p>The insurer or its delegated entity shall have a <u>written</u> quality assurance plan, updated <u>annually</u>, to systematically monitor, evaluate and develop recommendations for improvement of medical services provided to injured workers based on the <u>goal of returning injured employees to work</u> as soon as medically feasible.</p> <p>The plan shall specify:</p> <ul style="list-style-type: none"> 1) Criteria and standards for internal monitoring and problem solving activities;

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<p>community that will be conducted; (B) The <u>timeframes</u> and the <u>responsible individual</u> for each quality assurance activity; and (C) The follow-up activities including <u>written procedures</u> for taking <u>remedial action</u>.</p> <p>59A-23.004(3)(a-c) F.A.C.</p>	<ol style="list-style-type: none"> 2) Specific activities which will be conducted over the coming year to review and measure the appropriateness of medical services and meet the program's goals and objectives; 3) Methods and time frames for implementing the plan; 4) Timeframes for completion of activities; 5) Individuals responsible for each activity; and 6) Follow-up activities. <p>The annual plan should include specific activities for the components of the QA program listed under scope in Tag 3.</p> <p>Areas to be addressed in developing the plan should include:</p> <ol style="list-style-type: none"> 1) Criteria for selecting areas of study; 2) Frequency and duration of studies; 3) Selection process for data sources; 4) Line of authority/accountability; 5) Quality assurance committee selection criteria; 6) Method of reporting/recording outcomes of care; 7) Mechanism for follow-up; and 8) Trending, analysis, and recommendations for corrective action.
<p><u>WC 5</u></p> <p><u>QUALITY ASSURANCE-REMEDIAL ACTION</u></p> <p>The insurer or delegated entity shall have written <u>procedures</u> for taking <u>appropriate remedial action</u> whenever, as determined under the quality assurance program, <u>inappropriate or substandard services</u> have been provided or <u>services that should have been furnished have not been provided</u>.</p> <p>s. 440.134(6)(c) 3, F.S.</p>	<p>The insurer or delegated entity shall have a written policy and procedure for taking appropriate <u>remedial action</u> whenever, as determined under the quality assurance program, <u>inappropriate or substandard services</u> have been provided or <u>services that should have been furnished have not been provided</u>.</p> <p>The insurer or delegated entity shall <u>communicate its policy regarding disciplinary actions</u> for inappropriate or substandard medical services to providers <u>via provider educational materials/manuals</u>.</p>
<p><u>WC 6</u></p> <p><u>QUALITY ASSURANCE-COMMITTEE</u></p> <p>(A) The insurer or delegated entity shall have a <u>quality assurance committee</u> that meets <u>quarterly</u> to review the progress of quality assurance activities,</p>	<p>The quality assurance committee should meet <u>quarterly</u> to review progress on quality assurance activities, completion of the plan, findings, and to develop recommendations for</p>

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<p>completion of the <u>written work plan</u>, findings, and to develop recommendations for corrective action and follow-up.</p> <p>(B) The committee shall keep <u>minutes</u> of meetings to document the committee's activities. Activities of the committee shall include:</p> <ol style="list-style-type: none"> (1) Identification of data to be collected; (2) Evaluation of data collected; (3) Recommendation of improvements utilizing data collected; (4) <u>Communication</u> of the committee's findings to accountable authorities for implementation of improvements; and (5) Evaluation and documentation of the results of the implementation of improvements. <p>59A-23.004(4), F.A.C.</p> <p>(C) <u>Delegation</u>. The insurer shall conduct <u>oversight</u> of the delegated functions of the workers' compensation managed care arrangement. The insurer is responsible for the performance of all functions associated with the delivery of medical services to injured employees under Section 440.134(1)(g), F.S., regardless of whether the function has been delegated, by written agreement, to other entities. The insurer shall specify, in the written agreement, the oversight and reporting requirements for monitoring the performance of delegated functions. <u>Reports of subcontractors shall be evaluated no less than quarterly, and the findings incorporated into the insurer's quality assurance program.</u></p> <p>59A-23.003(8) F.A.C.</p>	<p>correction of problems and follow-up.</p> <p>The committee shall keep <u>minutes</u> of its meetings to document its activities included in Column 1.</p> <p>The quality assurance committee minutes shall incorporate quarterly reports from subcontractors regarding delegated quality assurance activities.</p>
<p><u>WC 7</u></p> <p><u>QUALITY ASSURANCE-PROCESS & OUTCOMES</u></p> <p>The insurer or delegated entity shall perform a <u>quality assurance review</u> of the <u>processes and outcomes of care</u>, at least <u>annually, using current state and nationally recognized practice guidelines</u>.</p> <p>59A-23.004(5) F.A.C.</p>	<p>The insurer or delegated entity shall as part of their quality assurance program, evaluate their outcomes of care and those processes employed to obtain those outcomes.</p> <p>The "Outcomes of Care" review shall be completed at least annually reported to the Quality Assurance committee.</p> <p>Current state and nationally recognized practice guidelines must be used to evaluate the insurers' or delegated entities' outcomes of care.</p>

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<p><u>WC 8</u></p> <p><u>QUALITY ASSURANCE-ORGANIZATIONAL CHANNELS</u></p> <p>All findings, conclusions, recommendations, actions taken and results of actions taken shall be documented, shared with contracted entities and reported through <u>organizational channels</u> that have been established within the workers' compensation managed care arrangement.</p> <p>59A-23.004(6), F.A.C.</p>	<p>The insurer or delegated entity shall develop and implement as part of their quality assurance policies and procedures a process for the reporting and sharing of quality assurance information between the insurer and the contracted entities. The policy and procedure shall include established organizational channels.</p> <p>The quality assurance committee shall document and share its findings, conclusions, recommendations, actions taken and results of actions taken for all activities throughout the total quality management processes.</p> <p><u>Delegation.</u> The insurer shall conduct <u>oversight</u> of the delegated functions of the workers' compensation managed care arrangement. The insurer is responsible for the performance of all functions associated with the delivery of medical services to injured employees under Section 440.134(1)(g), F.S., regardless of whether the function has been delegated, by written agreement, to other entities. The insurer shall specify, in the written agreement, the oversight and reporting requirements for monitoring the performance of delegated functions. <u>Reports of subcontractors shall be evaluated no less than quarterly, and the findings incorporated into the insurer's quality assurance program.</u></p> <p>59A-23.003(8), F.A.C.</p>
<p><u>WC 9</u></p> <p><u>QUALITY ASSURANCE – EMPLOYEE SATISFACTION</u></p> <p><u>The scope of the quality assurance program shall include satisfaction surveys.</u></p> <p>59A-23.004(2)(b), F.A.C.</p>	<p>The insurer or delegated entity shall conduct a survey of injured employees to assess satisfaction with services provided through the insurer or delegated entity. The findings of the survey shall be incorporated into the insurer or delegated entity's quality assurance program and appropriate action shall be taken to resolve problems identified by the survey.</p>
<p><u>WC 10</u></p> <p><u>QUALITY ASSURANCE-PEER REVIEW</u></p> <p>The quality assurance program shall include adequate methods of <u>peer</u></p>	<p>As part of the quality assurance program, the insurer or delegated entity shall provide an</p>

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<p><u>review.</u></p> <p>s. 440.134(6)(c) 6, F.S.</p> <p>The insurer or delegated entity shall provide, as part of the <u>quality assurance program</u>, an ongoing <u>peer review process</u> which:</p> <p>(A) Resolves issues regarding <u>provision of medical services</u>; and</p> <p>(B) Evaluates <u>clinical performance at least annually</u>.</p> <p>59A-23.004(7), F.A.C.</p>	<p>ongoing <u>peer view process</u> which</p> <p>1) Resolves issues regarding medical services; and</p> <p>2) <u>Evaluates clinical performance of providers at least annually</u>. The evaluation process shall include: <u>medical record audits</u> of a representative sample of providers to evaluate <u>medical necessity</u>; provision of medical service(s) <u>appropriate</u> to the diagnosis; <u>use of current state and nationally accepted practice parameters</u>; <u>timeliness and access to treatment</u>; and the development and use of a <u>plan of care</u>. The insurer or delegated entity shall have a <u>written methodology</u> for determining the size and scope of the <u>medical record audits</u> that shall reflect the volume and complexity of services provided by the provider network.</p> <p>59A-23.004(7)(b), F.A.C.</p> <p>“Peer review” means the evaluation of the treatment plan or clinical performance of providers by one or more licensed professionals with the same authority or similar specialty when potential quality of care issues have been identified through case management or quality assurance processes.</p> <p>59A-23.002(12) F.A.C.</p>
<p><u>WC 11</u></p> <p><u>QUALITY ASSURANCE - UTILIZATION MANAGEMENT</u></p> <p>(A) <u>Utilization Management</u>. The insurer or delegated entity shall have <u>written policies and procedures</u> for approving or denying requests for care in accordance with the agency’s <u>practice parameters</u>, and with <u>nationally recognized standards</u> based on <u>medical necessity</u>.</p> <p>59A-23.004(8), F.A.C.</p> <p>(B) The program shall evaluate <u>quality of care and services</u>, and provide <u>review prospectively, concurrently, and retrospectively</u> including pre-certification mechanisms for elective admissions and non-emergency surgeries.</p> <p>The utilization management program shall ensure that:</p> <p>(1) All <u>elective admissions and non-emergency services</u> must be <u>pre-certified</u>;</p> <p>(2) <u>Utilization management policies and procedures</u> are clearly defined in writing and any <u>advisory responsibilities</u> are assigned to individuals with <u>training and education</u> in a health care field sufficient to evaluate the</p>	<p>“Utilization management” means the examination and evaluation of health care services to determine the appropriate use of the resources and components available within the workers’ compensation managed care arrangement including, retrospective, concurrent, and prospective care reviews.</p> <p>59A-23.002(16), F.A.C.</p> <p>Care provided by the insurer or delegated entity is based on the foundation of medical necessity as per 440.13(1)(m), F.S. “Medically necessary” means 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.</p> <p>As part of the utilization management program, the insurer or delegated entity shall have written procedures and methods to prevent inappropriate or excessive treatments.</p> <p>s. 440.134(9), F.S.</p>

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<p>consistency of the proposed treatment with the relevant standards; (3) The utilization management program uses <u>nationally recognized written criteria based on clinical evidence to determine medical necessity</u>. Treating providers shall have access to the criteria used for determining medical necessity upon request; (4) <u>The medical care coordinator</u> is involved in the decision process and consultation regarding decisions with the treating physician. Any decision to <u>deny a request</u> for treatment shall be made by a <u>licensed</u> medical or osteopathic physician. <u>A physician not involved in the initial decision shall review any denial based on medical necessity</u>; (5) Decisions are made in a timely manner to accommodate the clinical urgency of the situation. There are <u>policies and procedures</u> and a process for making timely decisions including those involving <u>urgent care</u>; (6) The utilization management program <u>documents</u> and <u>communicates</u> the reasons for each <u>denial</u> of requested medical services to treating providers and the <u>injured employees</u>; (7) The information obtained through the <u>quality assurance program</u> is considered in evaluating the <u>timeliness</u> and <u>necessity</u> of medical services;</p> <p>59A-23.004(8)(a)1-7, F.A.C.</p>	<p>The insurer or delegated entity shall have utilization management policies and procedures clearly defined in writing that address:</p> <ol style="list-style-type: none"> 1) A pre-certification mechanism for elective admissions and non-emergency surgeries. The <u>utilization review process</u> shall include a <u>health care facilities pre-certification</u> mechanism, including, but <u>not limited to</u>, <u>all elective admissions</u> and <u>non-emergency surgeries</u>. s. 440.134(6)(c) 6, F.S.; 2) Any advisory responsibilities are assigned to individuals with training and education in a health care field sufficient to evaluate the consistency of the proposed treatment with the relevant standards; 3) Utilizing nationally recognized written criteria based on clinical evidence to determine medical necessity. That treating providers shall have access to the criteria used for determining medical necessity upon request; 4) The involvement of the medical care coordinator in the decision process and consultation regarding decisions with the treating physician. Any decision to deny a request for treatment shall be made by a licensed medical or osteopathic physician. A physician not involved in the initial decision shall review any denial based on medical necessity; 5) Assurance that decisions is made in a timely manner to accommodate the clinical urgency of the situation. There are policies and procedures and a process for making timely decisions including those involving urgent care; 6) The documentation and communication of the reasons for each denial of requested medical services to treating providers and the injured employees; and 7) The consideration of information obtained through the quality assurance program in evaluating the timeliness and necessity of medical services.
<p><u>WC 12</u></p> <p><u>QUALITY ASSURANCE - UTILIZATION MANAGEMENT- EXPERIMENTAL PROCEDURES</u></p> <p>There is a <u>procedure</u> for handling requests for <u>experimental procedures</u>;</p> <p>59A-23.004(8)(a)8, F.A.C.</p>	<p>The insurer or delegated entities shall have a policy and procedure for handling requests for experimental procedures. It should include a process of peer review and research to determine if a procedure is experimental, investigational or research nature. Services or treatment considered experimental, investigative, or research in nature must be approved by AHCA pursuant to s 440.13(1)(m), F.S.</p> <p>The service must not be of an experimental, investigative, or research nature, except in</p>

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	<p>those instances in which prior approval of the Agency for Health Care Administration has been obtained. The Agency for Health Care Administration shall adopt rules (Chapter 59B-11, F.A.C.) providing for such approval on a case-by-case basis when the service or supply is shown to have significant benefits to the recovery and well-being of the patient.</p> <p>s. 440.13(1)(m), F.S.</p>
<p><u>WC 13</u></p> <p><u>QUALITY ASSURANCE - UTILIZATION MANAGEMENT-DISPUTE RESOLUTION</u></p> <p><u>Provisions for resolution of disputes</u> arising between a <u>health care provider</u> and an <u>insurer</u> regarding <u>reimbursements and utilization review</u>.</p> <p>s. 440.134(6)(c) 7, F.S.</p> <p>There is a <u>procedure</u> for <u>resolution of provider disputes regarding reimbursement and utilization review</u>;</p> <p>59A-23.004(8)(a)9, F.A.C.</p>	<p>The insurer or delegated entity shall have a policy and procedure for resolution of provider disputes regarding reimbursement and utilization review.</p>
<p><u>WC 14</u></p> <p><u>QUALITY ASSURANCE - UTILIZATION MANAGEMENT-REFERRALS</u></p> <p>(A) There is a <u>procedure</u> for ensuring that <u>referrals are made to network providers</u> who are available and accessible within the <u>service area</u>. The insurer or delegated entity shall <u>monitor</u> the utilization of network and out-of-<u>network services</u> to improve network access; and</p> <p>59A-23.004(8)(a)10, F.A.C.</p> <p>(B) There is a <u>procedure</u> for <u>authorization of out-of-network services</u>.</p> <p>59A-23.004(8)(a)11, F.A.C.</p>	<p>The insurer or delegated entity shall have a policy and procedure ensuring that referrals are made to network providers within the service area.</p> <p>The insurer or delegated entity shall have a procedure to monitor the utilization of network and out of network services.</p> <p>The insurer or delegated entity shall have a written procedure for authorization of out of network services when those services are not available in the service area.</p>

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<p><u>WC 15</u></p> <p><u>QUALITY ASSURANCE - UTILIZATION MANAGEMENT</u></p> <p><u>Utilization management</u> is responsible for:</p> <p>(A) Selection and application of <u>nationally recognized review criteria and protocols</u>;</p> <p>(B) Recommendation of general utilization management program policies;</p> <p>(C) Overall program monitoring; and</p> <p>(D) Review of all <u>appeals of denials of requests for treatment or referrals</u>.</p> <p>59A-23.004(8)(b), F.A.C.</p>	<p>The insurer or delegated entity shall have written policies and procedures that define the responsibilities of utilization management pursuant to 59A-23.004(8)(b) F.A.C.</p>
<p><u>WC 16</u></p> <p><u>CASE MANAGEMENT –AGGRESSIVE MEDICAL CARE COORDINATION</u></p> <p>(A) Availability of a <u>process</u> for <u>aggressive medical care coordination</u>, as well as a program involving <u>cooperative efforts</u> by the workers, the employer, and the workers' compensation managed care arrangement <u>to promote early return to work</u> for injured workers.</p> <p>s. 440.134(6)(c) 8, F.S.</p> <p>(B) The <u>written information</u> proposed to be used by the insurer <u>to comply with subparagraph 8</u>.</p> <p>s. 440.134(6)(c) 11, F.S.</p>	<p>The insurer or delegated shall have policies and procedures and implement a system for providing aggressive medical care coordination services</p> <p>“Medical care coordination” means active case management and coordination of the health care services for an injured employee involving a medical care coordinator to ensure the delivery of necessary services in a manner which will return the individual to work as soon as feasible.</p> <p>59A-23.002(11) F.A.C.</p> <p>The policies and procedures shall include a <u>written program</u> or information that promotes involvement and <u>cooperative efforts</u> by the workers, the employer, and the workers' compensation managed care arrangement <u>to promote early return to work</u> for injured workers.</p>
<p><u>WC 17</u></p> <p><u>CASE MANAGEMENT</u></p> <p>The insurer or delegated entity shall specify the <u>types and severity of injuries which require internal and external case management</u>.</p> <p>59A-23.004(9), F.A.C.</p>	<p>The insurer or delegated entity shall have a policy and procedure and a process in place to determine what types and severity of injury require internal and external case management.</p>

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<p><u>WC 18</u></p> <p><u>CASEMANAGEMENT – INTERNAL CASE MANAGEMENT</u></p> <p>(A) Internal case management activities shall be performed in consultation with the treating physician and the <u>medical care coordinator</u>.</p> <p>59A-23.004(9)(b), F.A.C.</p> <p>(B) <u>Internal case management</u> services shall be provided by individuals with the <u>experience and training</u> required to perform their assigned responsibilities.</p> <p>59A-23.004(9)(c), F.A.C.</p>	<p>The insurer or delegated entity shall have policies and procedures to implement an internal case management system.</p> <p>“Internal case management” means a process for telephonically coordinating, facilitating, and monitoring all aspects of the medical care coordination of the injured employee in consultation with the treating physician and the medical care coordinator. 59A-23.002(10), F.A.C.</p> <p><u>Internal case management</u> activities shall include:</p> <ol style="list-style-type: none"> 1. Coordinating, facilitating, and monitoring all aspects of the ongoing medical care of the injured employee; 2. Communicating utilization management decisions to the <u>medical care coordinator</u> and treating providers; 3. Assisting the injured employee in <u>resolving complaints</u> and obtaining medically necessary services; 4. <u>Educating</u> injured employees regarding their rights, responsibilities, and limitations of the workers’ compensation managed care arrangement; 5. Coordinating, facilitating, and monitoring the injured employee’s <u>return to work status</u> including communicating to the claims representative the services required pursuant to Section 440.491, F.S.; and 6. Communicating the injured employee’s status to the employer and to the injured employee. <p>59A-23.004(9)(a), F.A.C.</p>
<p><u>WC 19</u></p> <p><u>CASE MANAGEMENT – EXTERNAL CASE MANAGEMENT</u></p> <p>(A) <u>External case management</u> shall be provided for <u>catastrophic injuries</u> as defined under Section 440.02(37), F.S., and for such other injuries as determined by the insurer or delegated entity.</p> <p>(B) External case management services shall be performed by <u>certified rehabilitation providers</u> approved pursuant to Section 440.491, F.S.</p>	<p>The insurer or delegated entity shall also provide care coordination services for catastrophic and other injuries as appropriate.</p> <p>“Catastrophic injury” means a permanent impairment constituted by:</p> <ol style="list-style-type: none"> (a) Spinal cord injury involving severe paralysis of an arm, a leg, or the trunk; (b) Amputation of an arm, a hand, a foot, or a leg involving the effective loss of use of the

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59A-23.004(9)(d), F.A.C.	<p>appendage;</p> <p>(c) Severe brain or closed-head injury as evidenced by;</p> <ol style="list-style-type: none"> 1. Severe sensory or motor disturbances; 2. Severe communication disturbances; 3. Severe complex integrated disturbances of cerebral function; 4. Severe episodic neurological disorders; or 5. Other severe brain and closed-head injury conditions at least as severe in nature as any condition provided in subparagraphs 1-4. <p>(d) 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;</p> <p>(e) Total or industrial blindness; or</p> <p>(f) 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 on July 1, 1992, without regard to any time limitations provided under that act.</p> <p>440.02(37), F.S.</p> <p>“External case management” means face-to-face medical care coordination performed by a <u>qualified rehabilitation provider</u> pursuant to Section 440.491, F.S.</p> <p>59A-23.002(7), F.A.C.</p>
<p><u>WC 20</u></p> <p><u>CASE MANAGEMENT - COMMUNICATION</u></p> <p>The insurer or delegated entity shall develop and implement <u>procedures</u> for <u>communication of information</u> regarding <u>medical services</u> and <u>return to work</u> between internal and external case management, the medical care coordinator, claims administration, the employer, and injured employee.</p> <p>59A-23.004(9)(e), F.A.C.</p>	<p>The insurer or delegated entity shall develop and implement procedures which promote effective communication among all parties; so as to facilitate the management of the medical care delivered to injured workers.</p>
<p><u>WC 21</u></p> <p><u>CASE MANAGEMENT – MCC</u></p> <p>The insurer or delegated entity shall designate one or more physicians as a <u>medical care coordinator</u> to manage medical care for injured workers. A <u>medical care coordinator</u> shall be assigned for each injured employee.</p>	<p>"Medical care coordinator" means 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</p>

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<p>59A-23.003(7)(g), F.A.C.</p>	<p>referred for evaluation or treatment. A medical care coordinator shall be a physician licensed under chapter 458 or an osteopath licensed under chapter 459. 440.134(1)(i), F.S.</p> <p>The medical care coordinator shall have experience or training in workers' compensation and be responsible for the following:</p> <ol style="list-style-type: none"> 1) Management of the medical treatment plan; 2) Participation in the <u>quality improvement</u> process and evaluation of <u>outcomes of care</u>; 3) Review of grievances; and 4) Authorization of referrals to <u>specialty providers for second opinions</u>, evaluation of treatment, including <u>changes to another specialty provider</u> pursuant to paragraph. 440.134(10)(c), F.S.
<p><u>WC 22</u></p> <p><u>CASE MANAGEMENT - MCC</u></p> <p>Written <u>procedures</u> and methods for the <u>management</u> of an injured worker's medical care by a <u>medical care coordinator</u> including:</p> <p>(A) The <u>mechanism</u> for assuring that covered employees receive all initial covered services from a <u>primary care provider</u> participating in the <u>provider network</u>, except for emergency care.</p> <p>(B) The <u>mechanism</u> for assuring that all continuing covered services be received from the <u>same primary care provider</u> participating in the provider <u>network</u> that provided the initial covered services, except when services from another provider are authorized by the medical care coordinator pursuant to paragraph (d).</p> <p>s. 440.134(10)(a)(b), F.S.</p> <p>(C) The <u>process</u> for assuring that <u>all referrals authorized by a medical care coordinator</u> are made to the participating <u>network providers</u>, unless medically necessary treatment, care, and attendance are not available and accessible to the injured worker in the provider network.</p> <p>s. 440.134(10)(d), F.S.</p>	<p>The insurer or delegated entity shall have a policy and procedure and implement a process assuring that injured employees receive <u>all initial covered services</u> from a primary care provider (PCP) participating in the provider network, except for emergency care. The insurer or delegated entity shall communicate its policy regarding PCPs to providers via the provider manual and other educational materials.</p> <p>The insurer or delegated entity shall have a policy and procedure and implement a process defining the role of a Medical Care Coordinator (MCC). The MCC shall be "a primary care provider within a provider network who is responsible for managing the medical care of an injured employee including determining other health care providers and health care facilities to which the injured employee will be referred for evaluation or treatment." s. 440.134(1)(i), F.S.</p> <p>The insurer or delegated entity shall communicate its policy on Medical Care Coordinators (MCCs) to providers via the provider manual and other educational materials.</p> <p>The insurer or delegated entity may also designate specialty physicians licensed under chapters 458 or 459, other than those listed in 440.134(1)(k), F.S., as primary care providers (PCP) and medical care coordinators provided that the process and criteria for designation is addressed by the insurer or delegated entity's policies and procedures.</p>

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	Employee educational material must contain a description of how to access emergency, initial, and continuing care and the role of the PCP and MCC.
<p><u>WC 23</u></p> <p><u>CASE MANAGEMENT – CHANGE OF PROVIDER</u></p> <p>The <u>policies and procedures</u> for allowing an employee <u>one change</u> to another provider within the same specialty and provider network as the authorized treating physician during the course of treatment for a work-related injury, if a request is made to the medical care coordinator by the employee; and requiring that special provision be made for more than one such referral through the arrangement's grievance procedures.</p> <p>s. 440.134(10)(c), F.S.</p>	<p>The insurer or delegated entity shall have a policy and procedure and implement a process for changing providers, including special provisions being made for more than one change through the arrangement's grievance procedure. The process shall be communicated to employees and providers via employee and provider educational materials/handbooks.</p>
<p><u>WC 24</u></p> <p><u>CASE MANAGEMENT – SECOND MEDICAL OPINION</u></p> <p>A <u>process</u> allowing employees to obtain <u>one second medical opinion</u> in the <u>same specialty</u> and within the provider network during the course of treatment for a work-related injury.</p> <p>s. 440.134(6)(c) 9, F.S.</p>	<p>The insurer or delegated entity shall have a policy and procedure and implement a process for injured employees to request and obtain a second medical opinion. The insurer or delegated entity shall communicate its policy and process to employees and providers via provider manuals, and employee orientation materials and employee handbooks.</p> <p>“Second medical opinion” means a consultation by a health care provider authorized by the medical care coordinator that requires at a minimum a history, an examination, and a straightforward medical decision to confirm or offer alternatives.</p> <p>59A-23.002(14), F.A.C.</p>
<p><u>WC 25</u></p> <p><u>CASE MANAGEMENT – PRIMARY CARE PHYSICIAN</u></p> <p>A <u>provision</u> for the <u>selection of a primary care provider by the employee</u> from among primary providers in the provider network.</p>	<p>The insurer or delegated entity, may direct injured employees to a single primary care provider or a selected group of primary care providers within the provider network for assessment and initial treatment. However, the employee shall have the right to select a</p>

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<p>s. 440.134(6)(c) 10, F.S.</p>	<p>primary care provider and thereafter, to request one change of primary care provider and of each authorized treating specialty provider during the course of treatment for each injury. The injured employee shall select a primary care provider from a current list of all primary care providers in the approved service area within 30 minutes average travel time of the employee's employment site. 59A-23.003(7)(i), F.A.C.</p> <p>"Primary care provider" means, except in the case of emergency treatment, the initial treating physician and, when appropriate, continuing treating physician, who 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; an optometrist licensed under chapter 463; or a dentist licensed under chapter 466. 440.134(1)(k), F.S.</p>
<p><u>WC 26</u></p> <p><u>MEDICAL INFORMATION/CASE FILES</u></p> <p>The insurer or delegated entity shall <u>implement a system for managing electronic and paper medical information</u> necessary to promote the prompt delivery of medical services in order to <u>return the injured employee to work</u> as soon as medically feasible.</p> <p>59A-23.005(1), F.A.C.</p>	<p>The insurer or delegated entity shall <u>implement a system for managing electronic and paper medical information.</u></p>
<p><u>WC 27</u></p> <p><u>MEDICAL RECORDS – CONSENT</u></p> <p>(A) <u>Provider Medical Records.</u> The insurer or delegated entity shall maintain or <u>assure that its providers maintain a medical records system</u>, which is consistent with professional standards, pursuant to <u>Section 456.057, F.S.</u></p> <p>59A-23.005(2), F.A.C.</p> <p>(B) Require the insurer or delegated entity to request <u>written consent</u> of patients for <u>release of medical records</u> that are subject to the limitations in <u>Sections 381.004 and 456.057, F.S.</u>, and for obtaining and sharing all documents and medical records from providers necessary to carry out the</p>	<p>The insurer or delegated entity shall develop and implement <u>policies and procedures</u> that:</p> <p>(a) Permit <u>prompt retrieval</u> of <u>legible</u> and timely information, which is accurately documented and readily available if requested by a health care practitioner with <u>written authorization and consent</u> from the patient when required by statute;</p> <p>(b) Protect the <u>confidentiality</u> and security of paper and electronic <u>patient records</u> including:</p> <ol style="list-style-type: none"> 1. Transfer, storage, and faxing of records; and 2. Handling of records containing information on <u>HIV, substance abuse, and mental health</u>, in accordance with statutory requirements; <p>(c) Provide for the <u>training and education</u> of administrative staff and providers on medical</p>

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<p>provisions of Section 440.134, F.S.; and Address transfer and retrieval of records, and provision of copies when requested by the patient, designated representative, or the Agency pursuant to Section 440.13(4)(c), F.S. The insurer or delegated entity shall communicate its policy to providers via <u>provider educational materials</u>.</p> <p>59A-23.005(2)(g)(h), F.A.C.</p>	<p>record documentation, policies and procedures, storage and confidentiality of patient records; 59A-23.005(2)(a-c), F.A.C.</p> <p>The insurer or delegated entity shall communicate its medical records policies and requirements to providers via provider education materials.</p>
<p><u>WC 28</u></p> <p><u>MEDICAL RECORDS -AUDITS</u></p> <p><u>Audits of provider records.</u> (A) The <u>insurer or delegated entity</u> shall implement an <u>ongoing process for conducting medical record audits</u> to determine compliance with the <u>medical record standards</u> specified under paragraphs (2)(d), (e) and (f). (B) The insurer or delegated entity shall have a <u>written methodology for determining the size and scope of the medical record audits</u> that shall reflect the volume and complexity of services provided by the provider network. (C) The insurer or delegated entity shall develop and implement an <u>annual work plan for the medical record audits</u>. (D) The results of the audits shall be <u>reported quarterly to the quality assurance committee</u> and shall include the following: (1) Number of physicians reviewed by county and by specialty; (2) Areas where specific improvements in record keeping are indicated; (3) Results from implementing improvements recommended in prior audits; (4) Recommendations for education and feedback to providers; and (5) Extent to which the physician's treatment plan was implemented.</p> <p>59A-23.005(4), F.A.C.</p>	<p>The insurer or delegated entity shall have policies and procedures and implement an ongoing process for the auditing of provider medical records which includes at a minimum:</p> <ol style="list-style-type: none"> 1) The methodology used to determine the size and scope of the audit; 2) The annual work plan indicating the ongoing schedule for audits and the responsible persons; and 3) A requirement for quarterly reporting of the audit results to the quality assurance committee which includes at a minimum (D) (1-5) from tag WC 28 in column 1. <p>59A-23.005(4)(a-e), F.A.C.</p> <p>The insurer or its delegated entity shall develop and implement policies and procedures for the inclusion of specific information in the provider's medical record. <u>Medical Records shall include:</u></p> <p><u>MEDICAL RECORDS - SUMMARY</u></p> <p>Document in the medical record a <u>summary, related to work injury or illness, of significant procedures, past and current diagnoses or problems and allergies and adverse reactions to current medications</u>;</p> <p>59A-23.005(2)(d), F.A.C.</p> <p><u>MEDICAL RECORDS – IDENTIFYING INFORMATION</u></p> <p><u>Identify the patient</u> as follows: 1. Name; 2. Social Security, alien identification number, or other identification number;</p>

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	<p>3. Date of Birth; Employer; home and work telephone numbers; 4. Sex; and 5. Date of work injury or illness.</p> <p>59A-23.005(2)(e)(1-5), F.A.C.</p> <p><u>MEDICAL RECORDS – EACH VISIT</u></p> <p>Indicate in the <u>medical record</u> for <u>each visit</u> the following information:</p> <ol style="list-style-type: none"> 1. Date; 2. Chief complaint, unresolved problems or complaints from prior interventions and purpose of visit; 3. Objective findings of practitioner; 4. Diagnosis or medical impression; 5. Studies ordered, for example: lab, x-ray, EKG, and referral reports; 6. Therapies administered and prescribed; 7. Name and profession of practitioner rendering services, for example: M.D., D.O., D.C., D.P.M., R.N., O.D., etc., including signature or initials of practitioner; 8. Disposition, recommendations, instructions, and education to the patient. Evidence of whether there was follow-up and the specific time of return is noted in weeks, months or as needed; 9. Outcome of services; 10. Work status, release for return to work, work restrictions; and 11. Evidence of coordination of care and any injured employee non-compliance with treatment. <p>59A-23.005(2)(f)(1-11), F.A.C.</p> <p>The insurer or delegated entity shall communicate its medical records policies and requirements to providers via provider education materials.</p>
<p><u>WC 29</u></p> <p><u>CASE FILES – SYSTEM</u></p> <p>(A) <u>Case Files</u>. The insurer or delegated entity shall <u>maintain electronic or paper medical information</u> necessary to ensure the efficient functioning of the</p>	<p>The insurer or delegated entity shall maintain an electronic or paper file for each injured employee, which contains medical information necessary to ensure the efficient</p>

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<p>care coordination process.</p> <p>59A-23.005(3), F.A.C.</p> <p>Written <u>procedures</u> to <u>provide</u> the insurer with <u>timely medical records and information</u> including, but not limited to, <u>work status, work restrictions, date of maximum medical improvement, permanent impairment ratings</u>, and other information as required.</p> <p>s. 440.134(7), F.S.</p> <p><u>CASE FILES - COORDINATION</u></p> <p>(B) <u>Case files shall contain necessary information for the coordination of quality patient care</u> between providers, insurers, employees, and employers including:</p> <ol style="list-style-type: none"> (1) The information from the notice of injury required by Section 440.13(4)(a), F.S.; (2) The current primary care physician, primary care physician changes and the designated medical care coordinator; (3) The treating physician's plan of care; 4. Medical reports and information necessary to support the coordination of medical care; (5) The injured employee's work status, work restrictions, date of maximum medical improvement, and permanent impairment ratings; and (6) Efforts toward rehabilitation and reemployment of the injured employee. <p>59A-23.005(3), F.A.C.</p>	<p>functioning of the care coordination process.</p> <p>The insurer or delegated entity shall have a written procedures and implement a process to <u>provide</u> the insurer with <u>timely medical records and information</u> including, but not limited to, <u>work status, work restrictions, date of maximum medical improvement, permanent impairment ratings</u>, and other information as required.</p> <p>The insurer or delegated entity shall develop and implement policies and procedures for the inclusion of specific information in the case file.</p> <p>The insurer or delegated entity shall communicate its case file policies, procedures and requirements to providers via provider education materials.</p>
<p><u>WC 30</u></p> <p><u>CASE FILES- CONFIDENTIALITY/SECURITY</u></p> <p>The insurer or delegated entity shall develop and implement a <u>policy and procedure</u> that protects the <u>confidentiality and security of case file</u></p>	<p>The insurer or delegated entity shall have a case file policy and procedures, and implement a process which addresses transfer, storage, confidentiality, security, and the provision of</p>

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<p>information including the transfer and storage of paper and electronic information, and the handling of information on HIV, substance abuse, and mental health.</p> <p>59A-23.005(3), F.A.C.</p>	<p>copies of paper and electronic case files, including provision for those files containing information concerning H.I.V., substance abuse, or mental health.</p>
<p><u>WC 31</u></p> <p><u>GRIEVANCE PROCEDURES</u></p> <p>Each insurer or delegated entity shall develop and implement a <u>grievance procedure</u> to resolve complaints and written grievances by employees and providers.</p> <p>59A-23.006(1), F.A.C.</p> <p>(A) A workers' compensation managed care arrangement must have and use <u>procedures for hearing complaints and resolving written grievances</u> from injured workers and health care providers. The procedures must be aimed at mutual agreement for settlement and may include <u>arbitration</u> procedures. Procedures provided herein are in addition to other procedures contained in this chapter.</p> <p>(B) The grievance <u>procedure</u> must be described in <u>writing</u> and <u>provided to</u> the affected workers and health care providers.</p> <p>(C) At the time the workers' compensation managed care <u>arrangement is implemented</u>, the insurer must <u>provide detailed information to workers</u> and health care <u>providers</u> describing how a grievance may be registered with the insurer.</p> <p>(D) Grievances must be considered in a <u>timely</u> manner and must be <u>transmitted to appropriate decision makers</u> who have the authority to fully investigate the issue and take corrective action.</p> <p>(E) If a grievance is found to be valid, <u>corrective action must be taken promptly</u>.</p> <p>(F) <u>All concerned parties must be notified of the results of a grievance</u>.</p> <p>s. 440.134(15)(a-f), F.S.</p>	<p>The insurer or delegated entity shall develop and implement a grievance procedure to resolve complaints and written grievances from injured workers and health care providers, which are aimed at mutual agreement for settlement. The procedures should include the following:</p> <ol style="list-style-type: none"> 1) Request for Services; 2) Complaint Procedure; and 3) Written Grievance. <p>The grievance procedure must be communicated to the affected workers and health care providers in writing at the time the time the insurer or delegated entity is implemented.</p> <p>All grievances must be considered by the appropriate authority in a timely manner and if found to be valid, corrective action must be taken promptly.</p> <p><u>All concerned parties must be notified of the results of a grievance.</u></p>

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<p><u>WC 32</u></p> <p><u>GRIEVANCE PROCEDURES - EDUCATION</u></p> <p>A detailed description of the employee complaint and grievance procedure shall be provided by the insurer or delegated entity to employees pursuant to Rule 59A-23.009, F.A.C.</p> <p>59A-23.006(2), F.A.C.</p>	<p>A detailed description of the employee complaint and written grievance procedures shall be included in <u>educational materials provided to injured employees</u>. A detailed description of the provider complaint and grievance procedure shall be included in educational materials given to providers.</p> <p>59A-23.006(2), F.A.C.</p>
<p><u>WC 33</u></p> <p><u>GRIEVANCE PROCEDURES – REQUEST FOR SERVICES</u></p> <p>The grievance procedure shall include the following: <u>Requests for services.</u> (A) The insurer or delegated entity shall implement a <u>procedure</u> to address <u>initial requests for services</u>. (B) The insurer or delegated entity shall evaluate requests for medical services within <u>seven calendar days</u> of receipt and shall notify the injured employee of the decision to grant the request, to deny it, or to request additional information. (C) When the insurer or delegated entity denies a request it shall notify the injured employee in writing of the denial and the <u>right to file a grievance</u>. The insurer or delegated entity shall provide the employee with a copy of AHCA Form No. 3160-0019 (November 2000) which is incorporated by reference. If the insurer or delegated entity <u>fails to respond within seven calendar days of receipt</u> of the request, the injured employee may make a complaint or file a written grievance.</p> <p>59A-23.006(4)(a), F.A.C.</p>	<p><u>REQUEST FOR SERVICES</u></p> <p>The insurer or delegated entity shall develop and implement policies and procedures governing <u>Initial Requests for Services</u>, which at a minimum, provide that:</p> <ol style="list-style-type: none"> 1) The employee shall be notified of the decision to grant or deny the request, or request additional information within seven (7) calendar days; 2) When a request is denied; notifies the employee in writing of their right to file a grievance; and 3) Provides to the employee a copy of the required grievance form (AHCA form No. 3160-0019). <p>Initial requests for services, such as a <u>request for medical services, second opinions, or a change in providers</u>, are not considered a complaint or grievance</p> <p>59A-23.006(4)(a), F.A.C.</p>

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<p><u>WC 34</u></p> <p><u>GRIEVANCE PROCEDURES - COMPLAINT</u></p> <p><u>Complaint Procedure.</u> (A) The insurer or delegated entity shall implement a <u>procedure</u> to address complaints about <u>medical issues and employees' rights</u> under Section 440.134, F.S., in a timely manner in order to expedite the resolution of issues of providers and injured employees. (B) The insurer or delegated entity shall investigate and resolve a complaint within <u>ten calendar days</u> of receipt unless the parties and the insurer or delegated entity mutually agree to an extension. The ten days shall commence upon receipt of a personal or telephone contact by the insurer or delegated entity from the injured employee, provider, designated representative, the Agency, or the Division. (C) If a complaint is <u>denied, or remains unresolved after ten days</u> of receipt, the insurer or delegated entity shall notify the affected parties in <u>writing of the right to file a written grievance.</u> (D) If the insurer or delegated entity denies a complaint, it shall notify the injured employee of the <u>reason for the denial.</u> The <u>written notification</u> shall include the name, title, address, and telephone number of the <u>grievance coordinator.</u> In addition, the insurer or delegated entity shall advise the injured employee of the right to contact the <u>Division's Employee Assistance Office</u> for additional information on rights and responsibilities and the dispute resolution process under Chapter 440, F.S., and related administrative rules.</p> <p>59A-23.006(4)(b), F.A.C.</p>	<p><u>COMPLAINT PROCEDURE</u></p> <p>“Complaint” means any dissatisfaction expressed by an injured worker as defined in Section 440.134(1)(b), F.S. An initial request for services, such as a request for medical services, second opinions, or a change in providers, is not considered a complaint. 59A-23.001(3), F.A.C.</p> <p>The insurer or delegated entity shall develop and implement policies and procedures governing Complaints, which at a minimum, provide that:</p> <ol style="list-style-type: none"> 1) Complaints will be investigated and resolved within ten (10) calendar days of receipt; 2) When a complaint is denied or remains unresolved after ten (10) calendar days: <ol style="list-style-type: none"> a) Notifies the affected parties of their right to file a grievance; b) Notifies the injured employee of the reason for the denial; c) The written notification shall include the name, title, address, and telephone number of the grievance coordinator; and d) Notifies the injured employee of their right to contact the Division's Employee Assistance Office. <p>The Employee Assistance Office is now part of the Department of Insurance, Division of Workers' Compensation.</p>
<p><u>WC 35</u></p> <p><u>GRIEVANCE PROCEDURES – GRIEVANCE FORM</u></p> <p>An injured employee or provider grievance shall be submitted on <u>AHCA Form No. 3160-0019, November 2000.</u> The insurer or delegated entity shall provide assistance to an injured employee unable to complete the grievance form and to those persons who have improperly filed a grievance.</p>	<p>The insurer or delegated entity shall develop and implement policies and procedures governing Written Grievances, which requires the use of AHCA form No. 3160-0019 for all formal grievances.</p> <p>The grievance form is available at:</p>

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59A-23.006(4)(c) 5, F.A.C.	www.fdhc.state.fl.us/MCHQ/Managed_Health_Care/WCMC Click on Workers' Compensation Managed Care Arrangements Go to forms.
<p><u>WC 36</u></p> <p><u>GRIEVANCE PROCEDURES - AVAILABILITY OF FORMS</u></p> <p>(A) A <u>copy of the grievance procedure and forms</u> for filing a written grievance shall be made available to providers, employees, or their designated representative <u>within seven calendar days of receipt of a request</u>.</p> <p>(B) Copies of the form required for filing a grievance shall also be <u>available at the same location as the compensation notice</u> required under Rule 38F-6.007, F.A.C. (The broken arm poster).</p> <p>(C) The insurer or delegated entity <u>shall not charge</u> the employer, employee, or provider for administering the grievance process.</p> <p>59A-23.006(3), F.A.C.</p>	<p>The insurer or delegated entity shall develop and implement policies and procedures governing availability and distribution of the grievance procedures and the required form (AHCA form No. 3160-0019), which comply with the time frames and locations as described in 59A-23.006(3), F.A.C.</p>
<p><u>WC 37</u></p> <p><u>GRIEVANCE PROCEDURES – WRITTEN</u></p> <p><u>Written Grievance.</u></p> <p>(A) The <u>procedure</u> for written grievances shall commence upon receipt of a <u>signed grievance form AHCA Form No. 3160-0019</u> (November 2000) by the insurer or delegated entity, from the injured employee, provider, or their designated representative. A written grievance may be submitted or withdrawn at any time. The injured employee or provider is not required to make a complaint prior to filing a written grievance.</p> <p>(B) The procedure shall include <u>notice to the employer when a grievance has been filed</u>.</p> <p>(C) The insurer or delegated entity shall notify the injured employee and employer in writing of the <u>resolution</u> of the written grievance, and the reasons therefore <u>within seven days of the final determination</u>.</p> <p>(D) The insurer or delegated entity shall implement an <u>expedited procedure for urgent grievances</u> to render a determination and notify the injured employee <u>within three calendar days</u> of receipt. <u>If the insurer or delegated entity has initiated an expedited grievance procedure, the injured employee</u></p>	<p><u>WRITTEN GRIEVANCE PROCEDURE</u></p> <p>“Grievance” means a written expression of dissatisfaction with medical care by an injured worker as defined in Section 440.134(1)(d), F.S. Initial written requests for medical services, second opinions, or changes in providers are not grievances. 59A-23.002(8)</p> <p>The insurer or delegated entity shall develop and implement policies and procedures governing written grievances, which at a minimum, provide for:</p> <ol style="list-style-type: none"> 1) Notification of the <u>employer</u> when a grievance has been filed; 2) Notification of the employee and employer in writing of the resolution of the grievance, and the reasons therefore within seven (7) days of the final determination; 3) An expedited procedure for urgent grievances; 4) A time frame for resolving a written grievance which is compliant with the provisions of 59A-23.006 (c) 2; and 5) A grievance committee in accordance with 59A-23.006 (c) 1-3.

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<p><u>shall be considered to have exhausted all managed care grievance procedures after three days from receipt.</u></p> <p>(E) Upon receipt of a written grievance, the <u>grievance coordinator</u> 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 within <u>14 calendar days</u> of receipt.</p> <p>(F) If the determination is not in favor of the aggrieved party the grievance coordinator shall notify the aggrieved party that the grievance is being <u>forwarded to the grievance committee</u> for further consideration unless withdrawn in writing by the employee or provider.</p> <p>(G) The <u>grievance committee</u> shall consist of not <u>less than three individuals</u>, of whom at least <u>one must be a physician other than the injured employee's treating physician</u>, who is <u>licensed under Chapter 458 or 459, F.S.</u>, and has <u>professional expertise relevant to the issue</u>.</p> <p>(H) The committee shall review information pertaining to the issues being grieved and render a <u>determination within 30 calendar days</u> of receipt of the grievance by the committee unless the grieving party and the committee mutually agree to an extension that is documented in writing. If the grievance involves the collection of <u>additional information from outside the service area</u>, the insurer or delegated entity will have <u>14 additional calendar days</u> to render a determination.</p> <p>(I) The insurer or delegated entity shall notify the employee in writing within <u>seven days</u> of receipt of the grievance by the committee if additional information is required to complete the review of the grievance.</p> <p>59A-23.006(4)(c) 1-3, F.A.C.</p>	
<p><u>WC 38</u></p> <p><u>GRIEVANCE PROCEDURES - ARBITRATION</u></p> <p>The insurer or delegated entity <u>may allow but may not require arbitration</u> as part of the grievance process. A grievance which is arbitrated pursuant to Chapter 682, Florida Statutes, is permitted an additional time limitation <u>not to exceed 210 calendar days</u> from the date the insurer or delegated entity receives a written request for arbitration from the injured employee. Arbitration provisions in a workers' compensation managed care arrangement</p>	<p><u>ARBITRATION</u></p> <p>The insurer or delegated entity shall develop and implement policies and procedures governing written grievances, which allows but does not require arbitration.</p>

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<p>shall not preclude the employee from filing a request for assistance with the Division of Workers' Compensation relating to non-medical issues.</p> <p>59A-23.006(4)(c) 4, F.A.C.</p>	
<p><u>WC 39</u></p> <p><u>GRIEVANCE PROCEDURES – PETITION FOR BENEFITS</u></p> <p>The claimant or provider shall be considered to have <u>exhausted</u> all managed care grievance procedures if a determination on a grievance has <u>not been rendered within the required timeframe</u> specified in this section or other timeframe, as mutually agreed to in writing by the grieving party and the insurer or delegated entity.</p> <p>59A-23.006(4)(c) 6, F.A.C.</p> <p>Upon <u>completion of the grievance</u> procedure, the insurer or delegated entity shall provide written notice to the employee of the <u>right to file a petition for benefits with the Division</u> pursuant to Section 440.192, F.S.</p> <p>59A-23.006(4)(c) 7, F.A.C.</p>	<p><u>PETITION FOR BENEFITS</u></p> <p>The insurer or delegated entity shall develop and implement policies and procedures governing Written Grievances, which provide for upon completion of the grievance procedure, provides written notice to the employee of the right to file a petition for benefits with the Division pursuant to Section 440.192, F.S.</p> <p>The Division of Workers' Compensation is now the Department of Insurance, Division of Workers' Compensation.</p>
<p><u>WC 40</u></p> <p><u>GRIEVANCES – COORDINATOR</u></p> <p>The insurer or delegated entity shall designate at least <u>one grievance coordinator</u> who is responsible for the implementation of the grievance procedure. The insurer or delegated entity shall ensure that the grievance coordinator's role in the grievance procedure is identified in the <u>grievance coordinator's job description</u>.</p> <p>59A-23.006(5), F.A.C.</p>	<p>The insurer or delegated entity shall develop and implement policies and procedures governing Written Grievances, which designates at least one grievance coordinator and identifies his or her role in the grievance process.</p>
<p><u>WC 41</u></p> <p><u>GRIEVANCES-PHONE NUMBER</u></p>	

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<p>The insurer or delegated entity shall provide <u>specified phone numbers</u> in the <u>provider and employee educational materials</u> for the employee or provider to contact the grievance coordinator. Each phone number shall be <u>toll free</u> within the injured employee's or provider's geographic service area and shall <u>provide access</u> without undue delays. There must be an adequate number of phone lines to handle incoming complaint calls.</p> <p>59A-23.006(6), F.A.C.</p>	<p>The insurer or delegated entity shall develop and implement policies and procedures governing Written Grievances, which at a minimum, provide for requires the inclusion in the employee and provider educational material of the phone number and mailing address of the grievance coordinator.</p>
<p><u>WC 42</u></p> <p><u>GRIEVANCES-ADDRESS</u></p> <p>The insurer or delegated entity shall provide a <u>current mailing address</u> in <u>employee and provider educational</u> materials that indicate where to file a grievance.</p> <p>59A-23.006(7), F.A.C.</p>	<p>The insurer or delegated entity shall develop and implement policies and procedures governing Written Grievances, which at a minimum, provide for requires the inclusion in the employee and provider educational material of the phone number and mailing address of the grievance coordinator.</p>
<p><u>WC 43</u></p> <p><u>GRIEVANCES-PHYSICIAN REVIEW</u></p> <p>Physician involvement in reviewing medically related grievances. This involvement shall not be limited to the injured employee's primary care physician, but shall include <u>at least one other physician</u>.</p> <p>59A-23.006(8), F.A.C.</p>	<p>The insurer or delegated entity shall develop and implement policies and procedures governing Written Grievances, which provides for Physician involvement in medically related grievances.</p>
<p><u>WC 44</u></p> <p><u>GRIEVANCES-MEETING</u></p> <p>A <u>meeting</u> between the insurer or delegated entity and the injured employee or provider during the written grievance process if requested by the injured employee or provider. The insurer or delegated entity shall offer to meet with the injured employee or provider at a <u>location</u> within the service area <u>convenient</u> to the injured employee or provider.</p> <p>59A-23.006(9), F.A.C.</p>	<p>The insurer or delegated entity shall develop and implement policies and procedures governing Written Grievances, which at a minimum, provides for a meeting between the employee and the insurer.</p>

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<p><u>WC 45</u></p> <p><u>GRIEVANCE FILES</u></p> <p>A record of each written grievance. The insurer or delegated entity will maintain a <u>record of each written grievance</u> to include the following:</p> <p>(A) A description of the grievance, the injured employee's or provider's name and address, the names and addresses of any treating workers' compensation providers relevant to the grievance, and the managed care arrangement name and address;</p> <p>(B) A complete description of the findings, including supportive documentation, conclusions and final disposition of the grievance; and</p> <p>(C) A statement as to the current status of the grievance.</p> <p>59A-23.006(10), F.A.C.</p>	<p><u>GRIEVANCE FILES</u></p> <p>The insurer or delegated entity shall maintain for each written grievance, a grievance file which is compliant with the provisions of 59A-23. 006 (10), F.A.C.</p>
<p><u>WC 46</u></p> <p><u>GRIEVANCES LOG</u></p> <p>The insurer or delegated entity shall maintain a <u>list of all grievance files</u> that contains the identity of the injured employee, the individual filing the grievance, the date filed, the nature of the grievance, the resolution, and the resolution date.</p> <p>59A-23.006(11), F.A.C.</p>	<p><u>GRIEVANCE LOG</u></p> <p>The insurer or delegated entity shall maintain a grievance log which is compliant with 59A-23. 006 (11) F.A.C.</p>
<p><u>WC 47</u></p> <p><u>GRIEVANCES-ANALYSIS</u></p> <p>The insurer or delegated entity shall be responsible for <u>regular and systematic review and analysis</u> of all written grievances for the purpose of identifying <u>trends or patterns</u>, and, upon emergence of any pattern, shall develop and implement recommendations for <u>corrective action</u>.</p>	<p><u>QUALITY ASSURANCE</u></p> <p>The insurer or delegated entity shall as part of their Quality Assurance Program track and trend all written grievances.</p>

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<p>59A-23.006(12), F.A.C.</p> <p><u>WC 48</u></p> <p><u>GRIEVANCES-ANNUAL REPORT</u></p> <p>An <u>annual report</u> of all grievances filed by employees and providers shall be submitted to the Agency pursuant to paragraph 440.134(15)(g), F.S. The report shall list the <u>number, nature, and resolution</u> of all written employee and provider grievances. This report shall be submitted no later than March 31 for grievances filed during the <u>previous calendar year</u> in a format prescribed by the Agency on AHCA Form No. 3160-0012 (July 1997). This form is hereby incorporated by reference and is available by contacting AHCA, 2727 Mahan Drive, Tallahassee, Florida 32308, Bureau of Managed Health Care, Workers' Compensation Managed Care Unit. It is also available at www.fdhc.state.fl.us/Managed Health Care/WCMC.</p> <p>59A-23.006(13), F.A.C.</p> <p>The insurer must <u>report annually</u>, no later than March 31, to the agency regarding its grievance procedure activities for the prior calendar year. The report must be in a format prescribed by the agency and must contain the <u>number</u> of grievances filed in the <u>past year</u> and a <u>summary of the subject, nature, and resolution</u> of such grievances.</p> <p>s. 440.134(15)(g), F.S.</p>	<p><u>ANNUAL REPORT</u></p> <p>The insurer or delegated entity shall submit to the Agency, an <u>accurate</u> annual report of all grievances received during the previous calendar year per 59A-23. 006 (13) F.A.C.</p> <p><u>The annual grievance activity report must be filed even if no grievances were received during the previous calendar year.</u></p> <p>The Annual Grievance Report form is available at: www.fdhc.state.fl.us/MCHQ/Managed_Health_Care/WCMC Click on Workers' Compensation Managed Care Arrangements Go to forms.</p>
<p><u>WC 49</u></p> <p><u>EDUCATION (EMPLOYEE)-PROCEDURE</u></p> <p><u>Employee Education.</u> The insurer or delegated entity in conjunction with the employer shall develop and implement <u>procedures</u> for the education of employees about the managed care process and requirements. The education procedures shall include: (A) <u>Orientation of all existing and new employees</u> to the requirements and limitations of the workers' compensation managed care arrangement. The employer shall display a <u>telephone number</u> for obtaining information about</p>	<p><u>EMPLOYEE EDUCATION</u></p> <p>The insurer or delegated entity shall develop policies and procedures and implement a process for the education of all employees which provides for:</p> <ol style="list-style-type: none"> 1) The orientation of all existing and new employees to the requirements and limitations of the workers' compensation managed care arrangement; 2) Provision of written education materials; and 3) Ongoing employee education about changes in the workers; compensation managed care arrangement.

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<p>the workers' compensation managed care arrangement in a prominent location in the workplace; (B) Provision of detailed employee <u>education materials</u> about the requirements and limitations of the workers' compensation managed care arrangement to the <u>injured employees</u>; and (C) <u>Ongoing education</u> of employees about <u>changes</u> in the workers' compensation managed care arrangement.</p> <p>59A-23.009(1)(a), F.A.C.</p>	<p>The <u>content of the employee educational material</u> shall include:</p> <ol style="list-style-type: none"> 1. The <u>rights and responsibilities</u> of the injured employee; 2. A description of the process for <u>accessing</u> medical care including the use of network providers, the primary care provider, medical care coordinator, case management, and the procedure to request a referral to a specialist; 3. The possible <u>effect</u> to the injured employee's health and benefits <u>for failure to use network providers or obtaining authorization for specialty care</u>; 4. A description of the <u>process for changing primary care and other specialty providers</u> once within the same specialty as the authorized treating physician during the course of treatment for a work-related injury; 5. A description of the <u>procedure</u> for obtaining a <u>second opinion</u>; 6. A <u>description of the complaint and grievance process</u> including the procedure to file a complaint or grievance, timeframes for completion of a complaint or grievance, and the availability of a grievance form; 7. The <u>toll free telephone number</u> of the <u>grievance coordinator</u>; and 8. The <u>telephone number of the Division of Workers' Compensation, Employee Assistance Office toll free hotline</u>. <p>59A-23.009(1)(b)(1-8), F.A.C.</p> <p>The Department of Labor and Employment Security, Division of Workers' Compensation is now under the Department of Insurance, Division of Workers' Compensation. The phone number for the Employee Assistance office has not changed.</p>
<p><u>WC 50</u></p> <p><u>EDUCATION- (EMPLOYEE) WRITTEN MATERIALS</u></p> <p>The insurer or delegated entity shall provide, either directly or indirectly, employee <u>educational materials written in language common to the workforce in the geographic service area</u>. Whether or not the employer has provided educational materials previously, the <u>educational material</u> shall be provided <u>to an injured employee within three calendar days of the date that the notice of injury</u> is filed by the insurance carrier or the employer.</p> <p>59A-23.009(1)(b), F.A.C.</p>	<p>The insurer or delegated entity shall develop policies and procedures and implement a process for the education of all employees which provides for:</p> <ol style="list-style-type: none"> 1) The education material provided to injured employees shall be in a language or languages common to the workforce in that geographic area; and 2) Complete written educational material will be provided to the injured worker within three calendar days of the date that the notice of injury is filed.
<p><u>WC 51</u></p> <p><u>EDUCATION (EMPLOYEE) DISCLOSURE</u></p>	

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<p>An insurer must make <u>full and fair disclosure</u> in writing of the provisions, restrictions, and limitations of the workers' compensation managed care arrangement to affected workers, including at least:</p> <p>(A) A description, including <u>address and phone number, of the providers</u>, including primary care physicians, specialty physicians, hospitals, and other providers.</p> <p>(B) A description of coverage for <u>emergency and urgently needed care</u> provided within and outside the service area.</p> <p>(C) A description of <u>limitations on referrals</u>.</p> <p>(D) A description of the <u>grievance procedure</u>.</p> <p>s. 440.134(14), F.S.</p>	<p>The <u>content of the employee educational material</u> shall include:</p> <ol style="list-style-type: none"> 1. The <u>rights and responsibilities</u> of the injured employee; 2. A description of the process for <u>accessing</u> medical care including the use of network providers, the primary care provider, medical care coordinator, case management, and the procedure to request a referral to a specialist; 3. The possible <u>effect</u> to the injured employee's health and benefits <u>for failure to use network providers or obtaining authorization for specialty care</u>; 4. A description of the <u>process for changing primary care and other specialty providers</u> once within the same specialty as the authorized treating physician during the course of treatment for a work-related injury; 5. A description of the <u>procedure</u> for obtaining a <u>second opinion</u>; 6. A <u>description of the complaint and grievance process</u> including the procedure to file a complaint or grievance, timeframes for completion of a complaint or grievance, and the availability of a grievance form; 7. The <u>toll free telephone number of the grievance coordinator</u>; and 8. The <u>telephone number of the Division of Workers' Compensation, Employee Assistance Office toll free hotline</u>. <p>59A-23.009(1)(b)(1-8), F.A.C.</p>
<p><u>WC 52</u></p> <p><u>EDUCATION (PROVIDER) 440 F.S. & 59A-23 F.A.C.</u></p> <p>(A) Evidence that appropriate health care providers and administrative staff of the insurer's workers' compensation managed care arrangement have received training and education on the provisions of this chapter and the administrative rules that govern the <u>provision of remedial treatment, care, and attendance of injured workers</u>.</p> <p>s. 440.134(8), F.S.</p> <p>(B) <u>Provider Education</u>. The insurer or delegated entity shall ensure that the health care providers within the provider network have received <u>training and education on the provisions of Chapter 440, F.S., and related administrative rules</u>. This shall be accomplished by a provider education program or verification that providers have previously received certification from the Division pursuant to Section 440.13, F.S.</p>	<p><u>PROVIDER EDUCATION</u></p> <p>The insurer or delegated entity shall develop policies and procedures, and implement a process for the education of the healthcare providers within the provider network which includes at a minimum:</p> <p>The insurer or delegated entity shall document to provision of provider and administrative staff education on the provisions of chapter 440.134,F.S. and 59-A-23, F.A.C.</p> <p>The provider <u>education program</u> shall address the following:</p> <ol style="list-style-type: none"> 1. The mission and goals of workers' compensation managed care; 2. Roles, rights, and responsibilities; 3. Provider network procedures; 4. Case management procedures; 5. Practice guidelines; 6. Utilization management procedures; 7. Peer review procedures;

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<p>59A-23.009(2), F.A.C.</p>	<p>8. Dispute resolution and grievance procedures; 9. Communication procedures between managed care components; 10. Medical records and case file procedures; 11. Workers' compensation managed care statutes and regulations relating to remedial treatment; and 12. The health care provider's role in successful return to work. The insurer or delegated entity shall identify those <u>ancillary providers</u> who require training on the provisions of workers' compensation medical services and shall provide and document the staff training and education program. 59A-23.009(2)(a)(1-12),(b), F.A.C.</p>
<p><u>WC 53</u></p> <p><u>EDUCATION (PROVIDER) ANNUAL</u></p> <p>The insurer or delegated entity shall provide such <u>ongoing provider education</u> at least annually to keep providers informed of changes in the processes of the workers' compensation managed care arrangement and to correct problems and implement recommendations of the quality assurance program. The insurer or delegated entity shall <u>document the provision of training</u>.</p> <p>59A-23.009(2)(c), F.A.C.</p>	<p>The insurer or delegated entity shall provide at least annually, ongoing education to its providers concerning changes to the processes of the insurer or delegated entity and to communicate recommendations made by the quality assurance committee. The insurer of delegated entity shall document the provision of such education.</p>
<p><u>WC 54</u></p> <p><u>EDUCATION ADMINISTRATIVE STAFF</u></p> <p><u>Administrative Staff Education.</u> (A) The insurer or delegated entity shall develop and implement a <u>policy and procedure</u>, and implement a process, to identify and train those administrative staff who require training on the provisions of Chapter 440, F.S., and related administrative rules. Administrative staff shall include <u>case managers, the grievance coordinator, and claims representatives</u>. (B) The insurer or delegated entity shall document the staff training and education program. (C) The program content shall address the following: (1) The mission and goals of workers' compensation managed care; (2) Roles, rights, and responsibilities; (3) Provider network procedures;</p>	<p><u>ADMINISTRATIVE STAFF</u></p> <p>The insurer or delegated entity shall develop policies and procedures, and implement a process for the education of their administrative staff.</p> <p>The insurer or delegated entity shall document the staff training and education program. The program content shall address the following: (a) The mission and goals of workers' compensation managed care; (b) Roles, rights, and responsibilities; (c) Provider network procedures; (d) Case management procedures; (e) Practice guidelines; (f) Utilization management procedures; (g) Peer review procedures;</p>

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<p>(4) Case management procedures; (5) Practice guidelines; (6) Utilization management procedures; (7) Peer review procedures; (8) Dispute resolution and grievance procedures; (9) Communication procedures between managed care components; and (10) Medical records and case files procedures.</p> <p>59A-23.009(3), F.A.C.</p>	<p>(h) Dispute resolution and grievance procedures; (i) Communication procedures between managed care components; and (j) Medical records and case files procedures. 59A-23.009(3)(a-j), F.A.C.</p> <p>The insurer or delegated entity shall document the training and education of the administrative staff.</p>