

AGENCY FOR HEALTH CARE ADMINISTRATION
 HEALTH QUALITY ASSURANCE – BUREAU OF MANAGED HEALTH CARE
 2727 Mahan Drive
 Tallahassee Florida 32308

WORKERS' COMPENSATION MANAGED CARE ARRANGEMENT SURVEY REPORT

NAME OF WCMCA / WCMCO _____

ADDRESS _____

CONTACT PERSON _____

SURVEYORS _____ DATE OF SURVEY _____

STANDARD	MET	NOT MET	NA	COMMENTS
<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>				

s. 440.134(6)(c) 1, 2, F.S.				
<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><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><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> <p>(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 community that will be conducted;</p> <p>(B) The <u>timeframes</u> and the <u>responsible individual</u> for each quality assurance activity; and</p> <p>(C) The follow-up activities including <u>written procedures</u> for taking remedial action.</p> <p>59A-23.004(3)(a-c) F.A.C.</p>				
<p><u>WC 5</u></p> <p><u>QUALITY ASSURANCE-REMEDIAL ACTION</u></p> <p>The WCMCA 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</u> have not been provided.</p> <p>s. 440.134(6)(c) 3, F.S.</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, 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> <ul 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</u></p>				
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<p><u>insurer's quality assurance program.</u> 59A-23.003(8) F.A.C.</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 of the processes and outcomes of care</u>, at least <u>annually</u>, using <u>current state and nationally recognized practice guidelines</u>.</p> <p>59A-23.004(5) F.A.C.</p>				
<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><u>WC 9</u></p> <p><u>QUALITY ASSURANCE – EMPLOYEE SATISFACTION</u></p> <p>The scope of the quality assurance program shall include <u>satisfaction surveys</u></p> <p>59A-23.004(2)(b), F.A.C.</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 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><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>(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 consistency of the proposed treatment with the relevant standards;</p> <p>(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;</p> <p>(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 medical or osteopathic physician</u>. <u>A physician not involved in the initial decision shall review any denial based on medical necessity</u>;</p> <p>(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>;</p> <p>(6) The utilization management program <u>documents and communicates</u> the reasons for each <u>denial</u> of requested medical services to treating <u>providers and the injured employees</u>;</p>				
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<p>(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><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.004(8)(a)8, F.A.C.</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><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>59A23 .004(8)(a)11, F.A.C.</p>				
<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><u>WC 16</u></p> <p><u>CASE MANAGEMENT –AGGRESSIVE MEDICAL CARE COORDINATION</u></p> <p>(A) Availability of a <u>process for 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 to</p>				

<p><u>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 to <u>comply with subparagraph 8</u>.</p> <p>s. 440.134(6)(c) 11, F.S.</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><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><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>59A-23.004(9)(d), 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><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 medical care coordinator shall be assigned for each injured employee.</p>				

59A-23.003(7)(g)				
<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 <u>provider 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 <u>participating 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><u>WC 23</u></p> <p><u>CASE MANAGEMENT – CHANGE OF PROVIDER</u></p> <p>The policies and procedures 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><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><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>s. 440.134(6)(c) 10, F.S.</p>				

<p><u>WC 26</u></p> <p><u>MEDICAL RECORDS</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. 59A-23.005(1), F.A.C.</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 assure that its providers maintain a <u>medical records system</u>, which is consistent with professional standards, pursuant to <u>Section 456.057, F.S.</u> 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 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</u></p>				

<u>educational materials.</u> 59A-23.005(2)(g)(h), F.A.C.				
<u>WC 28</u> <u>MEDICAL RECORDS -AUDITS</u> <u>Audits of provider records.</u> (A) The insurer or delegated entity shall implement an <u>ongoing process for conducting medical record audits</u> to determine compliance with the medical record standards 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. 59A-23.005(4), F.A.C.				

<p><u>WC 29</u></p> <p><u>CASE FILES – SYSTEM</u></p> <p>Written <u>procedures to provide the insurer with 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>(A) 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 care coordination process.</p> <p>59A-23.005(3), F.A.C.</p> <p><u>CASE FILES - COORDINATION</u></p> <p><u>(B) 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 				
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<p>the injured employee.</p> <p>59A-23.005(3), F.A.C.</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> 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><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. 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</p>				

<p><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><u>WC 32</u> <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><u>WC 33</u> <u>GRIEVANCE PROCEDURES – REQUEST FOR SERVICES</u></p> <p>The grievance procedure shall include the following: <u>Requests for services.</u></p> <p>(A) The insurer or delegated entity shall implement a <u>procedure</u> to address <u>initial requests for services</u>.</p> <p>(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.</p>				

<p>(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>WC 34</u></p> <p><u>GRIEVANCE PROCEDURES - COMPLAINT</u></p> <p><u>Complaint Procedure.</u></p> <p>(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.</p> <p>(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.</p> <p>(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>.</p> <p>(D) If the insurer or delegated entity denies a complaint,</p>				

<p>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; and</p> <p>59A-23.006(4)(b), F.A.C.</p>				
<p><u>WC 35</u></p> <p><u>GRIEVANCE PROCEDURES – 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>59A-23.006(4)(c) 5, F.A.C.</p>				
<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</p>				

<p>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><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 within <u>three calendar days</u> of receipt. <u>If the insurer or delegated entity has initiated an expedited grievance procedure, the injured employee shall be considered to have exhausted</u></p>				

<p><u>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</p>				
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<p>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 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</p>				

<p>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>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 grievance <u>coordinator’s job description</u>.</p> <p>59A-23.006(5), F.A.C.</p>				
<p><u>WC 41</u></p> <p><u>GRIEVANCES-PHONE NUMBER</u></p> <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><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 materials</u> that indicate where to file a grievance.</p> <p>59A-23.006(7), F.A.C.</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><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><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: (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; (B) A complete description of the findings, including supportive documentation, conclusions and final disposition of the grievance; and (C) A statement as to the current status of the grievance.</p> <p>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>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</p>				

<p>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>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. 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 <u>prior calendar year</u>. 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>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:</p> <ul style="list-style-type: none"> (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 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>59A-23.009(1)(a), F.A.C.</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</u> written in language common to the workforce in the <u>geographic service area</u>. Whether or not the employer</p>				

<p>has provided educational materials previously, the <u>educational material</u> shall be provided to an <u>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><u>WC 51</u> <u>EDUCATION (EMPLOYEE) DISCLOSURE</u></p> <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><u>WC 52</u> <u>EDUCATION (PROVIDER) 440 F.S. AND 59A 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</u></p>				

<p><u>workers.</u></p> <p>s. 440.134(8), F.S.</p> <p><u>(B) 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>59A-23.009(2), 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 at least annually</u> 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><u>WC 54</u></p> <p><u>EDUCATION ADMINISTRATIVE STAFF</u></p> <p><u>Administrative Staff Education.</u></p> <p>(A) The insurer or delegated entity shall develop a <u>policy and procedure,</u> and implement a process, to identify and train those administrative staff who require trainings on the provisions of Chapter 440, F.S., and related administrative</p>				

<p>rules. Administrative staff shall include <u>case managers, the grievance coordinator, and claims representatives.</u></p> <p>(B) The insurer or delegated entity shall document the staff training and education program.</p> <p>(C) The program content shall address the following:</p> <ul 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; (8) Dispute resolution and grievance procedures; (9) Communication procedures between managed care components; and (10) Medical records and case files procedures. <p>59A-23.009(3), F.A.C.</p>				