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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.
### WC 1

**QUALITY ASSURANCE – QA PROGRAM**

The insurer or delegated entity shall have a description of the quality assurance program which assures that the health care services provided to workers shall be rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the medical community.

The program shall include, but not be limited to:
1. A written statement of goals and objectives that stresses health and return-to-work outcomes as the principal criteria for the evaluation of the quality of care rendered to injured workers.
2. A written statement describing how methodology has been incorporated into an ongoing system for monitoring of care that is individual case oriented and, when implemented, can provide interpretation and analysis of patterns of care rendered to individual patients by individual providers.

s. 440.134(6)(c) 1, 2, F.S.

### WC 2

**QUALITY ASSURANCE – QA PROGRAM**

Each insurer or delegated entity shall have an ongoing quality assurance program designed to objectively and systematically monitor and evaluate the quality of patient care, based upon the prevailing standards of medical practice in the community.

59A-23.004(1), F.A.C.

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:
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.
## WC 3
### QUALITY ASSURANCE – SCOPE

The scope of the quality assurance program shall include the following:

1. **Peer review**;
2. **Satisfaction survey**;
3. **Utilization management**;
4. **Case management**;
5. **Complaints and grievances**;
6. **Credentialing and recredentialing**;
7. **Medical records**;
8. **Return to work**;
9. **Cost analysis**;
10. **Data collection**;
11. **Outcome studies**;
12. **Education**;
13. **Provider dispute resolution**.

59A-23.004(2), F.A.C.

## WC 4
### QUALITY ASSURANCE – ANNUAL PLAN

The quality assurance plan shall be in writing, updated annually, and shall describe the program’s objectives, organization and problem-solving activities for improvement of medical services.

The plan shall specify:
1. Those specific activities under the ongoing quality assurance program designed to objectively and systematically monitor and evaluate the quality of patient care, based upon the prevailing standards of medical practice in the

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The insurer or delegated entity shall have a written policy and procedure and implement the quality assurance process.

The insurer or delegated entity shall have a policy and procedure, which outlines the scope of the quality assurance program. The scope shall include the components listed in column 1.

Individual components will be addressed under separate tags.

The insurer or its delegated entity shall have a written quality assurance plan, updated annually, to systematically monitor, evaluate and develop recommendations for improvement of medical services provided to injured workers based on the goal of returning injured employees to work as soon as medically feasible.

The plan shall specify:
1) Criteria and standards for internal monitoring and problem solving activities;
community that will be conducted; (B) The timeframes and the responsible individual for each quality assurance activity; and (C) The follow-up activities including written procedures for taking remedial action.

59A-23.004(3)(a-c) F.A.C.

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. The annual plan should include specific activities for the components of the QA program listed under scope in Tag 3.

Areas to be addressed in developing the plan should include: 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.

**WC 5**

**QUALITY ASSURANCE–REMEDIAL ACTION**

The insurer or delegated entity shall have written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services that should have been furnished have not been provided.

s. 440.134(6)(c) 3, F.S.

The insurer or delegated entity shall have a written policy and procedure for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services that should have been furnished have not been provided.

The insurer or delegated entity shall communicate its policy regarding disciplinary actions for inappropriate or substandard medical services to providers via provider educational materials/manuals.

**WC 6**

**QUALITY ASSURANCE–COMMITTEE**

(A) The insurer or delegated entity shall have a quality assurance committee that meets quarterly to review the progress of quality assurance activities,

The quality assurance committee should meet quarterly to review progress on quality assurance activities, completion of the plan, findings, and to develop recommendations for...
**INTERPRETIVE GUIDELINES**

**WORKERS’ COMPENSATION MANAGED CARE ARRANGEMENTS**

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<td>completion of the written work plan, findings, and to develop recommendations for corrective action and follow-up. (B) The committee shall keep minutes of meetings to document the committee’s activities. Activities of the committee shall include: (1) Identification of data to be collected; (2) Evaluation of data collected; (3) Recommendation of improvements utilizing data collected; (4) Communication 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.</td>
<td>correction of problems and follow-up. The committee shall keep minutes of its meetings to document its activities included in Column 1.</td>
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59A-23.004(4), F.A.C.

(C) Delegation. The insurer shall conduct oversight 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. Reports of subcontractors shall be evaluated no less than quarterly, and the findings incorporated into the insurer’s quality assurance program.

59A-23.003(8) F.A.C.

**QUALITY ASSURANCE-PROCESS & OUTCOMES**

The insurer or delegated entity shall perform a quality assurance review of the processes and outcomes of care, at least annually, using current state and nationally recognized practice guidelines.

59A-23.004(5) F.A.C.

The quality assurance committee minutes shall incorporate quarterly reports from subcontractors regarding delegated quality assurance activities.

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.

The “Outcomes of Care” review shall be completed at least annually reported to the Quality Assurance committee.

Current state and nationally recognized practice guidelines must be used to evaluate the insurers’ or delegated entities’ outcomes of care.
## WC 8
### QUALITY ASSURANCE-ORGANIZATIONAL CHANNELS

All findings, conclusions, recommendations, actions taken and results of actions taken shall be documented, shared with contracted entities and reported through organizational channels that have been established within the workers’ compensation managed care arrangement.

59A-23.004(6), F.A.C.

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.

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.

Delegation. The insurer shall conduct oversight 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. Reports of subcontractors shall be evaluated no less than quarterly, and the findings incorporated into the insurer’s quality assurance program.

59A-23.003(8), F.A.C.

## WC 9
### QUALITY ASSURANCE – EMPLOYEE SATISFACTION

The scope of the quality assurance program shall include satisfaction surveys.

59A-23.004(2)(b), F.A.C.

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.

## WC 10
### QUALITY ASSURANCE-PEER REVIEW

The quality assurance program shall include adequate methods of peer

As part of the quality assurance program, the insurer or delegated entity shall provide an...
review.

s. 440.134(6)(c) 6, F.S.

The insurer or delegated entity shall provide, as part of the quality assurance program, an ongoing peer review process which:

(A) Resolves issues regarding provision of medical services; and
(B) Evaluates clinical performance at least annually.

59A-23.004(7), F.A.C.

ongoing peer view process which

1) Resolves issues regarding medical services; and
2) Evaluates clinical performance of providers at least annually. The evaluation process shall include: medical record audits of a representative sample of providers to evaluate medical necessity; provision of medical service(s) appropriate to the diagnosis; use of current state and nationally accepted practice parameters; timeliness and access to treatment; and the development and use of a plan of care. The insurer or delegated entity shall have a written methodology for determining the size and scope of the medical record audits that shall reflect the volume and complexity of services provided by the provider network.

59A-23.004(7)(b), F.A.C.

“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.

59A-23.002(12) F.A.C.

WC 11

QUALITY ASSURANCE - UTILIZATION MANAGEMENT

(A) Utilization Management. The insurer or delegated entity shall have written policies and procedures for approving or denying requests for care in accordance with the agency’s practice parameters, and with nationally recognized standards based on medical necessity.

59A-23.004(8), F.A.C.

(B) The program shall evaluate quality of care and services, and provide review prospectively, concurrently, and retrospectively including precertification mechanisms for elective admissions and non-emergency surgeries.

The utilization management program shall ensure that:

1) All elective admissions and non-emergency services must be pre-certified;
2) Utilization management policies and procedures are clearly defined in writing and any advisory responsibilities are assigned to individuals with training and education in a health care field sufficient to evaluate the

“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.

59A-23.002(16), F.A.C.

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.

As part of the utilization management program, the insurer or delegated entity shall have written procedures and methods to prevent inappropriate or excessive treatments.

s. 440.134(9), F.S.
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<td>(3) The utilization management program uses nationally recognized written criteria based on clinical evidence to determine medical necessity. Treating providers shall have access to the criteria used for determining medical necessity upon request;</td>
<td>The insurer or delegated entity shall have utilization management policies and procedures clearly defined in writing that address:</td>
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<td>(4) The medical care coordinator is involved 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;</td>
<td>1) A pre-certification mechanism for elective admissions and non-emergency surgeries. The utilization review process shall include a health care facilities pre-certification mechanism, including, but not limited to, all elective admissions and non-emergency surgeries. s. 440.134(6)(c), F.S.;</td>
</tr>
<tr>
<td>(5) Decisions are 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;</td>
<td>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;</td>
</tr>
<tr>
<td>(6) The utilization management program documents and communicates the reasons for each denial of requested medical services to treating providers and the injured employees;</td>
<td>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;</td>
</tr>
<tr>
<td>(7) The information obtained through the quality assurance program is considered in evaluating the timeliness and necessity of medical services;</td>
<td>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;</td>
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59A-23.004(8)(a)1-7, F.A.C.

| WC 12 |
| QUALITY ASSURANCE - UTILIZATION MANAGEMENT-EXPERIMENTAL PROCEDURES |

There is a procedure for handling requests for experimental procedures; | 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. The service must not be of an experimental, investigative, or research nature, except in |

59A-23.004(8)(a)8, F.A.C.
### WC 13

**QUALITY ASSURANCE - UTILIZATION MANAGEMENT - DISPUTE RESOLUTION**

Provisions for resolution of disputes arising between a health care provider and an insurer regarding reimbursements and utilization review.

s. 440.134(6)(c) 7, F.S.

There is a procedure for resolution of provider disputes regarding reimbursement and utilization review:

59A-23.004(8)(a)9, F.A.C.

The insurer or delegated entity shall have a policy and procedure for resolution of provider disputes regarding reimbursement and utilization review.

### WC 14

**QUALITY ASSURANCE - UTILIZATION MANAGEMENT - REFERRALS**

(A) There is a procedure for ensuring that referrals are made to network providers who are available and accessible within the service area. The insurer or delegated entity shall monitor the utilization of network and out-of-network services to improve network access; and

59A-23.004(8)(a)10, F.A.C.

(B) There is a procedure for authorization of out-of-network services.

59A-23.004(8)(a)11, F.A.C.

The insurer or delegated entity shall have a policy and procedure ensuring that referrals are made to network providers within the service area.

The insurer or delegated entity shall have a procedure to monitor the utilization of network and out of network services.

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.
## QUALITY ASSURANCE - UTILIZATION MANAGEMENT

Utilization management is responsible for:

(A) Selection and application of nationally recognized review criteria and protocols;
(B) Recommendation of general utilization management program policies;
(C) Overall program monitoring; and
(D) Review of all appeals of denials of requests for treatment or referrals.

59A-23.004(8)(b), F.A.C.

### WC 16

**CASE MANAGEMENT – AGGRESSIVE MEDICAL CARE COORDINATION**

(A) Availability of a process for aggressive medical care coordination, as well as a program involving cooperative efforts by the workers, the employer, and the workers' compensation managed care arrangement to promote early return to work for injured workers.

s. 440.134(6)(c) 8, F.S.

(B) The written information proposed to be used by the insurer to comply with subparagraph 8.

s. 440.134(6)(c) 11, F.S.

### WC 17

**CASE MANAGEMENT**

The insurer or delegated entity shall specify the types and severity of injuries which require internal and external case management.

59A-23.004(9), F.A.C.
## WC 18

### CASE MANAGEMENT – INTERNAL CASE MANAGEMENT

- **(A)** Internal case management activities shall be performed in consultation with the treating physician and the medical care coordinator.

  59A-23.004(9)(b), F.A.C.

- **(B)** Internal case management services shall be provided by individuals with the experience and training required to perform their assigned responsibilities.

  59A-23.004(9)(c), F.A.C.

The insurer or delegated entity shall have policies and procedures to implement an internal case management system.

“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.

**Internal case management** activities shall include:

1. Coordinating, facilitating, and monitoring all aspects of the ongoing medical care of the injured employee;
2. Communicating utilization management decisions to the medical care coordinator and treating providers;
3. Assisting the injured employee in resolving complaints and obtaining medically necessary services;
4. Educating injured employees regarding their rights, responsibilities, and limitations of the workers’ compensation managed care arrangement;
5. Coordinating, facilitating, and monitoring the injured employee’s return to work status 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.

59A-23.004(9)(a), F.A.C.

## WC 19

### CASE MANAGEMENT – EXTERNAL CASE MANAGEMENT

- **(A)** External case management shall be provided for catastrophic injuries as defined under Section 440.02(37), F.S., and for such other injuries as determined by the insurer or delegated entity.

- **(B)** External case management services shall be performed by certified rehabilitation providers approved pursuant to Section 440.491, F.S.

The insurer or delegated entity shall also provide care coordination services for catastrophic and other injuries as appropriate.

“Catastrophic injury” means a permanent impairment constituted by:

(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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<td>59A-23.004(9)(d), F.A.C.</td>
<td>appendage; (c) Severe brain or closed-head injury as evidenced by; 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. (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; (e) Total or industrial blindness; or (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. 440.02(37), F.S.</td>
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**WC 20**

**CASE MANAGEMENT - COMMUNICATION**

The insurer or delegated entity shall develop and implement procedures for communication of information regarding medical services and return to work between internal and external case management, the medical care coordinator, claims administration, the employer, and injured employee.

59A-23.004(9)(c), F.A.C.

**WC 21**

**CASE MANAGEMENT – MCC**

The insurer or delegated entity shall designate one or more physicians as a medical care coordinator to manage medical care for injured workers. A medical care coordinator shall be assigned for each injured employee.

"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 referred.

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59A-23.003(7)(g), F.A.C.

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.

The medical care coordinator shall have experience or training in workers’ compensation and be responsible for the following:

1) Management of the medical treatment plan;
2) Participation in the quality improvement process and evaluation of outcomes of care;
3) Review of grievances; and
4) Authorization of referrals to specialty providers for second opinions, evaluation of treatment, including changes to another specialty provider pursuant to paragraph. 440.134(10)(c), F.S.

WC 22

Case Management - MCC

Written procedures and methods for the management of an injured worker’s medical care by a medical care coordinator including:

(A) The mechanism for assuring that covered employees receive all initial covered services from a primary care provider participating in the provider network, except for emergency care.

(B) The mechanism for assuring that all continuing covered services be received from the same primary care provider participating in the provider network that provided the initial covered services, except when services from another provider are authorized by the medical care coordinator pursuant to paragraph (d).

s. 440.134(10)(a)(b), F.S.

(C) The process for assuring that all referrals authorized by a medical care coordinator are made to the participating network providers, unless medically necessary treatment, care, and attendance are not available and accessible to the injured worker in the provider network.

s. 440.134(10)(d), F.S.

The insurer or delegated entity shall have a policy and procedure and implement a process assuring that injured employees receive all initial covered services 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.

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.

The insurer or delegated entity shall communicate its policy on Medical Care Coordinators (MCCs) to providers via the provider manual and other educational materials.

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.
### INTERPRETIVE GUIDELINES
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<td>The policies and procedures for allowing an employee one change 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.</td>
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<td>s. 440.134(10)(c), F.S.</td>
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<td>Employee educational material must contain a description of how to access emergency, initial, and continuing care and the role of the PCP and MCC.</td>
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<td>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.</td>
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<td>A process allowing employees to obtain one second medical opinion in the same specialty and within the provider network during the course of treatment for a work-related injury.</td>
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<td>s. 440.134(6)(c) 9, F.S.</td>
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<tr>
<td>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.</td>
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<tr>
<td>“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. 59A-23.002(14), F.A.C.</td>
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<td>A provision for the selection of a primary care provider by the employee from among primary providers in the provider network.</td>
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<td>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</td>
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### WC 26

**MEDICAL INFORMATION/CASE FILES**

The insurer or delegated entity shall implement a system for managing electronic and paper medical information necessary to promote the prompt delivery of medical services in order to return the injured employee to work as soon as medically feasible.

59A-23.005(1), F.A.C.

### WC 27

**MEDICAL RECORDS – CONSENT**

(A) Provider Medical Records. The insurer or delegated entity shall maintain or assure that its providers maintain a medical records system, which is consistent with professional standards, pursuant to Section 456.057, F.S.

59A-23.005(2), F.A.C.

(B) Require the insurer or delegated entity to request written consent of patients for release of medical records that are subject to the limitations in Sections 381.004 and 456.057, F.S., and for obtaining and sharing all documents and medical records from providers necessary to carry out the

The insurer or delegated entity shall develop and implement policies and procedures that:

- Permit prompt retrieval of legible and timely information, which is accurately documented and readily available if requested by a health care practitioner with written authorization and consent from the patient when required by statute;
- Protect the confidentiality and security of paper and electronic patient records including:
  1. Transfer, storage, and faxing of records; and
  2. Handling of records containing information on HIV, substance abuse, and mental health, in accordance with statutory requirements;
- Provide for the training and education of administrative staff and providers on medical

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s. 440.134(6)(c) 10, F.S.

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-23.005(7)(i), F.A.C.

"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.
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 provider educational materials.

59A-23.005(2)(g)(h), F.A.C.

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<td>record documentation, policies and procedures, storage and confidentiality of patient records; 59A-23.005(2)(a-c), F.A.C.</td>
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<tr>
<td>The insurer or delegated entity shall communicate its medical records policies and requirements to providers via provider education materials.</td>
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**WC 28**

**MEDICAL RECORDS - AUDITS**

Audits of provider records.
(A) The insurer or delegated entity shall implement an ongoing process for conducting medical record audits 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 written methodology for determining the size and scope of the medical record audits 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 annual work plan for the medical record audits.
(D) The results of the audits shall be reported quarterly to the quality assurance committee 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.

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:
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.

59A-23.005(4)(a-e), F.A.C.

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. Medical Records shall include:

**MEDICAL RECORDS - SUMMARY**

Document in the medical record a summary, related to work injury or illness, of significant procedures, past and current diagnoses or problems and allergies and adverse reactions to current medications;

59A-23.005(2)(d), F.A.C.

**MEDICAL RECORDS – IDENTIFYING INFORMATION**

Identify the patient as follows:
1. Name;
2. Social Security, alien identification number, or other identification number;
## Interpretive Guidelines

### Workers’ Compensation Managed Care Arrangements

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<td>3. Date of Birth; Employer; home and work telephone numbers; 4. Sex; and 5. Date of work injury or illness.</td>
<td>59A-23.005(2)(e)(1-5), F.A.C.</td>
</tr>
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### Medical Records – Each Visit

Indicate in the medical record for each visit the following information:

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  

59A-23.005(2)(f)(1-11), F.A.C.

The insurer or delegated entity shall communicate its medical records policies and requirements to providers via provider education materials.

### Case Files – System

(A) **Case Files.** The insurer or delegated entity shall maintain electronic or paper medical information necessary to ensure the efficient functioning of the

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
### Interpretive Guidelines

**Workers’ Compensation Managed Care Arrangements**

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<td>care coordination process.</td>
<td>functioning of the care coordination process.</td>
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59A-23.005(3), F.A.C.

Written procedures to provide the insurer with timely medical records and information including, but not limited to, work status, work restrictions, date of maximum medical improvement, permanent impairment ratings, and other information as required.

s. 440.134(7), F.S.

**CASE FILES - COORDINATION**

(B) Case files shall contain necessary information for the coordination of quality patient care between providers, insurers, employees, and employers including:

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.

59A-23.005(3), F.A.C.

The insurer or delegated entity shall have a written procedures and implement a process to provide the insurer with timely medical records and information including, but not limited to, work status, work restrictions, date of maximum medical improvement, permanent impairment ratings, and other information as required.

**CASE FILES - CONFIDENTIALITY/SECURITY**

The insurer or delegated entity shall develop and implement policies and procedures for the inclusion of specific information in the case file.

The insurer or delegated entity shall communicate its case file policies, procedures and requirements to providers via provider education materials.

The insurer or delegated entity shall develop and implement a policy and procedure that protects the confidentiality and security of case file.

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...
information including the transfer and storage of paper and electronic information, and the handling of information on HIV, substance abuse, and mental health.

59A-23.005(3), F.A.C.

**GRIEVANCE PROCEDURES**

Each insurer or delegated entity shall develop and implement a grievance procedure to resolve complaints and written grievances by employees and providers.

59A-23.006(1), F.A.C.

(A) A workers' compensation managed care arrangement must have and use procedures for hearing complaints and resolving written grievances from injured workers and health care providers. The procedures must be aimed at mutual agreement for settlement and may include arbitration procedures. Procedures provided herein are in addition to other procedures contained in this chapter.

(B) The grievance procedure must be described in writing and provided to the affected workers and health care providers.

(C) At the time the workers' compensation managed care arrangement is implemented, the insurer must provide detailed information to workers and health care providers describing how a grievance may be registered with the insurer.

(D) Grievances must be considered in a timely manner and must be transmitted to appropriate decision makers who have the authority to fully investigate the issue and take corrective action.

(E) If a grievance is found to be valid, corrective action must be taken promptly.

(F) All concerned parties must be notified of the results of a grievance.

s. 440.134(15)(a-f), F.S.
### WC 32

**GRIEVANCE PROCEDURES - EDUCATION**

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.

59A-23.006(2), F.A.C.

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### WC 33

**GRIEVANCE PROCEDURES – REQUEST FOR SERVICES**

The grievance procedure shall include the following:

**Requests for services.**

(A) The insurer or delegated entity shall implement a procedure to address initial requests for services.

(B) The insurer or delegated entity shall evaluate requests for medical services within seven calendar days 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 right to file a grievance. 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 fails to respond within seven calendar days of receipt of the request, the injured employee may make a complaint or file a written grievance.

59A-23.006(4)(a), F.A.C.

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**REQUEST FOR SERVICES**

The insurer or delegated entity shall develop and implement policies and procedures governing Initial Requests for Services, which at a minimum, provide that:

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).

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

59A-23.006(4)(a), F.A.C.
GRIEVANCE PROCEDURES - COMPLAINT

Complaint Procedure.

(A) The insurer or delegated entity shall implement a procedure to address complaints about medical issues and employees’ rights 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 ten calendar days 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 denied, or remains unresolved after ten days of receipt, the insurer or delegated entity shall notify the affected parties in writing of the right to file a written grievance.

(D) If the insurer or delegated entity denies a complaint, it shall notify the injured employee of the reason for the denial. The written notification shall include the name, title, address, and telephone number of the grievance coordinator. In addition, the insurer or delegated entity shall advise the injured employee of the right to contact the Division’s Employee Assistance Office for additional information on rights and responsibilities and the dispute resolution process under Chapter 440, F.S., and related administrative rules.

COMPLAINT PROCEDURE

“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.

The insurer or delegated entity shall develop and implement policies and procedures governing Complaints, which at a minimum, provide that:

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:
   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.

The Employee Assistance Office is now part of the Department of Insurance, Division of Workers’ Compensation.

GRIEVANCE PROCEDURES – GRIEVANCE FORM

An injured employee or provider grievance shall be submitted on AHCA Form No. 3160-0019, November 2000. 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.

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.

The grievance form is available at:
## INTERPRETIVE GUIDELINES
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<td><a href="http://www.fdhc.state.fl.us/MCHQ/Managed_Health_Care/WCMC">www.fdhc.state.fl.us/MCHQ/Managed_Health_Care/WCMC</a> Click on Workers’ Compensation Managed Care Arrangements Go to forms.</td>
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### WC 36

**GRIEVANCE PROCEDURES - AVAILABILITY OF FORMS**

- **(A)** A copy of the grievance procedure and forms for filing a written grievance shall be made available to providers, employees, or their designated representative within seven calendar days of receipt of a request.
- **(B)** Copies of the form required for filing a grievance shall also be available at the same location as the compensation notice required under Rule 38F-6.007, F.A.C. (The broken arm poster).
- **(C)** The insurer or delegated entity shall not charge the employer, employee, or provider for administering the grievance process.

59A-23.006(3), F.A.C.

### WC 37

**GRIEVANCE PROCEDURES – WRITTEN**

**Written Grievance.**

- **(A)** The procedure for written grievances shall commence upon receipt of a signed grievance form AHCA Form No. 3160-0019 (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.
- **(B)** The procedure shall include notice to the employer when a grievance has been filed.
- **(C)** The insurer or delegated entity shall notify the injured employee and employer in writing of the resolution of the written grievance, and the reasons therefore within seven days of the final determination.
- **(D)** The insurer or delegated entity shall implement an expedited procedure for urgent grievances to render a determination and notify the injured employee within three calendar days of receipt. If the insurer or delegated entity has initiated an expedited grievance procedure, the injured employee

**WRITTEN GRIEVANCE PROCEDURE**

“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)

The insurer or delegated entity shall develop and implement policies and procedures governing written grievances, which at a minimum, provide for:

1) Notification of the employer 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.
shall be considered to have exhausted all managed care grievance procedures after three days from receipt.

(E) Upon receipt of a written grievance, the grievance coordinator shall gather and review medical and related information pertaining to the issues being grieved. The grievance coordinator shall consult with appropriate parties and shall render a determination on the grievance within 14 calendar days of receipt.

(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 forwarded to the grievance committee for further consideration unless withdrawn in writing by the employee or provider.

(G) The grievance committee shall consist of not less than three individuals, of whom at least one must be a physician other than the injured employee’s treating physician, who is licensed under Chapter 458 or 459, F.S., and has professional expertise relevant to the issue.

(H) The committee shall review information pertaining to the issues being grieved and render a determination within 30 calendar days 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 additional information from outside the service area, the insurer or delegated entity will have 14 additional calendar days to render a determination.

(I) The insurer or delegated entity shall notify the employee in writing within seven days of receipt of the grievance by the committee if additional information is required to complete the review of the grievance.

59A-23.006(4)(c) 1-3, F.A.C.

**ARBITRATION**

The insurer or delegated entity shall develop and implement policies and procedures governing written grievances, which allows but does not require arbitration.

**GRIEVANCE PROCEDURES - ARBITRATION**

The insurer or delegated entity may allow but may not require arbitration as part of the grievance process. A grievance which is arbitrated pursuant to Chapter 682, Florida Statutes, is permitted an additional time limitation not to exceed 210 calendar days 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
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<td>The claimant or provider shall be considered to have exhausted all managed care grievance procedures if a determination on a grievance has not been rendered within the required timeframe specified in this section or other timeframe, as mutually agreed to in writing by the grieving party and the insurer or delegated entity.</td>
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<td>Upon completion of the grievance procedure, the insurer or delegated entity shall provide written notice to the employee of the right to file a petition for benefits with the Division pursuant to Section 440.192, F.S.</td>
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<th>WC 40</th>
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<td>The insurer or delegated entity shall designate at least one grievance coordinator 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 coordinator’s job description.</td>
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<th>WC 41</th>
<th><strong>GRIEVANCES-PHONE NUMBER</strong></th>
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<td>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.</td>
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shall not preclude the employee from filing a request for assistance with the Division of Workers’ Compensation relating to non-medical issues.

59A-23.006(4)(c) 4, F.A.C.
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<td>The insurer or delegated entity shall provide specified phone numbers in the provider and employee educational materials for the employee or provider to contact the grievance coordinator. Each phone number shall be toll free within the injured employee’s or provider’s geographic service area and shall provide access without undue delays. There must be an adequate number of phone lines to handle incoming complaint calls.</td>
<td>The insurer or delegated entity shall develop and implement policies and procedures governing Written Grievances, which at a minimum, provide for the inclusion in the employee and provider educational material of the phone number and mailing address of the grievance coordinator.</td>
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| **WC 42**
**GRIEVANCES-ADDRESS**
The insurer or delegated entity shall provide a current mailing address in employee and provider educational materials that indicate where to file a grievance. | The insurer or delegated entity shall develop and implement policies and procedures governing Written Grievances, which at a minimum, provide for the inclusion in the employee and provider educational material of the phone number and mailing address of the grievance coordinator. |
| **WC 43**
**GRIEVANCES-PHYSICIAN REVIEW**
Physician involvement in reviewing medically related grievances. This involvement shall not be limited to the injured employee’s primary care physician, but shall include at least one other physician. | The insurer or delegated entity shall develop and implement policies and procedures governing Written Grievances, which provides for Physician involvement in medically related grievances. |
| **WC 44**
**GRIEVANCES-MEETING**
A meeting 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 location within the service area convenient to the injured employee or provider. | 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. |

59A-23.006(6), F.A.C.
59A-23.006(7), F.A.C.
59A-23.006(8), F.A.C.
59A-23.006(9), F.A.C.
# INTERPRETIVE GUIDELINES
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### WC 45
**GRIEVANCE FILES**
A record of each written grievance. The insurer or delegated entity will maintain a record of each written grievance 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.

59A-23.006(10), F.A.C.

### WC 46
**GRIEVANCES LOG**
The insurer or delegated entity shall maintain a list of all grievance files 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.

59A-23.006(11), F.A.C.

### WC 47
**GRIEVANCES-ANALYSIS**
The insurer or delegated entity shall be responsible for regular and systematic review and analysis of all written grievances for the purpose of identifying trends or patterns, and, upon emergence of any pattern, shall develop and implement recommendations for corrective action.

### GRIEVANCE FILES
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.

### GRIEVANCE LOG
The insurer or delegated entity shall maintain a grievance log which is compliant with 59A-23. 006 (11) F.A.C.

### QUALITY ASSURANCE
The insurer or delegated entity shall as part of their Quality Assurance Program track and trend all written grievances.
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**WC 48**

**GRIEVANCES-ANNUAL REPORT**

An annual report 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 number, nature, and resolution of all written employee and provider grievances. This report shall be submitted no later than March 31 for grievances filed during the previous calendar year 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.

The insurer must report annually, 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 number of grievances filed in the past year and a summary of the subject, nature, and resolution of such grievances.

s. 440.134(15)(g), F.S.

**WC 49**

**EDUCATION (EMPLOYEE)-PROCEDURE**

Employee Education.

The insurer or delegated entity in conjunction with the employer shall develop and implement procedures for the education of employees about the managed care process and requirements. The education procedures shall include:

(A) Orientation of all existing and new employees to the requirements and limitations of the workers’ compensation managed care arrangement. The employer shall display a telephone number for obtaining information about

**ANNUAL REPORT**

The insurer or delegated entity shall submit to the Agency, an accurate annual report of all grievances received during the previous calendar year per 59A-23. 006 (13) F.A.C.

The annual grievance activity report must be filed even if no grievances were received during the previous calendar year.

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.

**EMPLOYEE EDUCATION**

The insurer of delegated entity shall develop policies and procedures and implement a process for the education of all employees which provides for:

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.
the workers’ compensation managed care arrangement in a prominent location in the workplace; (B) Provision of detailed employee education materials about the requirements and limitations of the workers’ compensation managed care arrangement to the injured employees; and (C) Ongoing education of employees about changes in the workers’ compensation managed care arrangement.

59A-23.009(1)(a), F.A.C.

The content of the employee educational material shall include:
1. The rights and responsibilities of the injured employee;
2. A description of the process for accessing 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 effect to the injured employee’s health and benefits for failure to use network providers or obtaining authorization for specialty care;
4. A description of the process for changing primary care and other specialty providers 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 procedure for obtaining a second opinion;
6. A description of the complaint and grievance process 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 toll free telephone number of the grievance coordinator; and
8. The telephone number of the Division of Workers’ Compensation, Employee Assistance Office toll free hotline.

59A-23.009(1)(b)(1-8), F.A.C.

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.

**WC 50**

**EDUCATION- (EMPLOYEE) WRITTEN MATERIALS**

The insurer or delegated entity shall provide, either directly or indirectly, employee educational materials written in language common to the workforce in the geographic service area. Whether or not the employer has provided educational materials previously, the educational material shall be provided to an injured employee within three calendar days of the date that the notice of injury is filed by the insurance carrier or the employer.

59A-23.009(1)(b), F.A.C.

**WC 51**

**EDUCATION (EMPLOYEE) DISCLOSURE**

The insurer of delegated entity shall develop policies and procedures and implement a process for the education of all employees which provides for:
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.
An insurer must make full and fair disclosure in writing of the provisions, restrictions, and limitations of the workers' compensation managed care arrangement to affected workers, including at least:

(A) A description, including address and phone number, of the providers, including primary care physicians, specialty physicians, hospitals, and other providers.

(B) A description of coverage for emergency and urgently needed care provided within and outside the service area.

(C) A description of limitations on referrals.

(D) A description of the grievance procedure.

s. 440.134(14), F.S.

The content of the employee educational material shall include:

1. The rights and responsibilities of the injured employee;

2. A description of the process for accessing 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 effect to the injured employee’s health and benefits for failure to use network providers or obtaining authorization for specialty care;

4. A description of the process for changing primary care and other specialty providers 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 procedure for obtaining a second opinion;

6. A description of the complaint and grievance process 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 toll free telephone number of the grievance coordinator; and

8. The telephone number of the Division of Workers' Compensation, Employee Assistance Office toll free hotline.

s. 440.134(14), F.S.

PROVIDER EDUCATION

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:

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.

The provider education program shall address the following:

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;

s. 440.134(14), F.S.
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<td>11. Workers’ compensation managed care statutes and regulations relating to remedial treatment; and</td>
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<td>12. The health care provider’s role in successful return to work.</td>
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<td>The insurer or delegated entity shall identify those ancillary providers who require training on the provisions of workers’ compensation medical services and shall provide and document the staff training and education program.</td>
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<td>59A-23.009(2)(a)(1-12),(b), F.A.C.</td>
<td>WC 53</td>
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**EDUCATION (PROVIDER) ANNUAL**

The insurer or delegated entity shall provide such ongoing provider education 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 document the provision of training.

59A-23.009(2)(c), F.A.C.

**WC 54**

**EDUCATION ADMINISTRATIVE STAFF**

Administrative Staff Education.

(A) The insurer or delegated entity shall develop and implement a policy and procedure, 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 case managers, the grievance coordinator, and claims representatives.

(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;

(4) The insurer or delegated entity shall document the provision of such education.

**ADMINISTRATIVE STAFF**

The insurer or delegated entity shall develop policies and procedures, and implement a process for the education of their administrative staff.

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;
### INTERPRETIVE GUIDELINES
#### WORKERS’ COMPENSATION MANAGED CARE ARRANGEMENTS

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