

CHAPTER 59A-23 WORKERS' COMPENSATION MANAGED CARE ARRANGEMENTS

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59A-23.001 Scope.

The following rules developed by the Agency for Health Care Administration govern the authorization of workers' compensation managed care arrangements pursuant to the Authority set forth in Chapter 440, F.S. *Specific Authority 440.134(2)(a) FS. Law Implemented 440.134 FS. History--New 9-12-94.*

59A-23.002 Definitions.

(1) "Agency" means the Agency for Health Care Administration.

(2) "Case files" means a system for managing medical information and return to work information regarding the injured employee, whether in electronic or paper format.

(3) "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.

(4) "Delegated entity" means a unit or single organization authorized by written agreement to act on behalf of the insurer to provide managed care services.

(5) "Credentialing" means the process for validating and evaluating the qualifications of a licensed health care provider to participate in a workers' compensation managed care arrangement provider network.

(6) "Division" means the Division of Workers' Compensation of the Florida Department of Labor and Employment Security.

(7) "External case management" means face-to-face medical care coordination performed by a qualified rehabilitation provider pursuant to Section 440.491, F.S.

(8) "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.

(9) "Insurer" means an entity which contracts to provide workers' compensation insurance coverage as defined under Section 440.134(1)(e), F.S.

(10) "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.

(11) "Medical care coordination" means active case management and coordination of the health care services for an injured employee involving a medical care coordinator to ensure the delivery of necessary services in a manner which will return the individual to work as soon as feasible.

(12) "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.

(13) "Quality assurance" means a formal set of activities, which review and safeguard the quality of medical services provided to the injured employee. Quality assurance includes assessment and implementation of corrective actions to address any deficiencies identified in the quality of care and services provided to the injured employee.

(14) "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.

(15) "Service area" means a geographic area consisting of a county or group of counties which shall not be subdivided for purposes of authorizing a workers' compensation managed care arrangement.

(16) "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.

(17) “Urgent” means that in the judgment of the primary care physician or medical care coordinator, the injured employee’s clinical condition requires a response within 72 hours, and the clinical condition is at significant risk of deterioration if a response is not made within that timeframe.

(18) “Written agreement” means an express, legally executed, written contract between two or more parties which specifies the following: the parties to the contract; the effective date of the contract; duties of the respective parties; reporting and or oversight of the responsibilities to be performed; performance standards; termination and expiration terms of the contract.

(19) “Workers’ Compensation managed care arrangement” means those arrangements as defined under Section 440.134(1)(g), F. S.

Specific Authority 440.134 FS. Law Implemented 440.134(1)(g), (5)(a), (6)(b), (c), (c)4., 6.-9., (9), (10), (14)(b), (d), (16), (17), (25)(b), (c), (d),(g) FS. History–New 9-12-94, Amended 10-8-01, 1-22-02.

59A-23.003 Authorization Procedures.

(1) General Provisions. All insurers offering a managed care arrangement for the provision of health services for the treatment of persons filing workers’ compensation claims shall obtain an authorization from the agency in accordance with the following procedures:

(a) Applications for an initial authorization, amendment of the authorized plan of operation, or renewal shall be submitted with the following:

1. A completed copy of AHCA Form 3160-0004, November 2000, incorporated by reference herein;
2. Required attachments as specified in AHCA Form 3160-0004, November 2000; and
3. Written agreements linking the entities within the managed care arrangement and specifying the duties of each entity. Application forms are available from and shall be submitted to the Agency for Health Care Administration, Division of Managed Care and Health Quality, Bureau of Managed Health Care, 2727 Mahan Drive, Mail Stop 45, Tallahassee, Florida 32308.

(b) An initial application for authorization shall be submitted to the agency at least 90 days prior to the intended date of implementation of services. An amendment application shall be submitted to the agency 60 days prior to the effective date of the proposed change in the plan of operation. Upon receipt of the application the agency shall review the content to determine compliance with the requirements of paragraphs 440.134(5) through (15), F.S.

(c) The agency shall notify applicants for initial or renewal authorization in writing via certified mail of any deficiencies in the application within 30 days of the receipt of the application. The applicant shall provide information necessary to complete the application within 30 days of receipt of the written notice. Failure to timely submit the necessary information shall result in denial of the application unless the applicant needs an extension of time due to circumstances beyond its control and requests the extension within 30 days of its receipt of the written notice of deficiencies. No extensions shall exceed 90 days or the expiration date of the workers’ compensation managed care arrangement.

(d) The agency shall provide notice to the applicant of its right to administrative review under Sections 120.569 and 120.57, F.S., with its written notice of intent to deny an application.

(e) Applications to amend an approved plan of operation by replacing the delegated managed care organization or provider network shall address the continuity of care and coordination of medical services for injured employees during the transition. The applicant shall submit information that identifies the activities to be conducted, persons involved, and dates for completion of the following tasks:

1. The identification and authorization of out of network services for injured employees whose current primary treating physician is not in the new provider network and who prefer to continue with their current provider;
2. The transfer of injured employees’ current medical care management information to the newly contracted entity; and
3. The notification of employers and employees of the requirements of the new network arrangements and the contact persons via the educational materials required under Sections 440.134(14)(a) through (d), F.S.

(f) Examination. The agency shall conduct an on-site survey of the managed care arrangement, within the first year of operation and no less than every two years thereafter, to determine compliance with the requirements of Section 440.134, F.S. The agency shall verify through subsequent survey that any deficiency identified during a previous survey is corrected. The agency may verify the correction without on-site resurvey if written documentation has been received from the insurer or delegated entity and is accepted by the agency. The agency shall also investigate on-site any alleged pattern of non-compliance with the requirements of Section 440.134, F.S.

(2) Fees. All initial and renewal applications for authorization of a workers' compensation managed care arrangement shall be accompanied by a fee of \$1,000 made payable to the agency. Applications to amend an existing authorized workers' compensation managed care arrangement do not require submission of a fee.

(3) Authorization for a workers' compensation managed care arrangement shall not be sold, assigned, or otherwise transferred either voluntarily or involuntarily and is valid only for the legal entity to which it was originally issued.

(4) Validity. Each authorization shall be valid for a period of two years only for:

(a) The entity to which it is issued as specified on the authorization letter; and

(b) The service area approved by the agency.

(5) Service areas. Each application shall indicate the geographic service area or areas in which the insurer or delegated entity will provide managed care services. The insurer shall offer a managed care arrangement only to those employers whose place of business or business operations are located in a service area approved by the agency to provide services under a workers' compensation managed care arrangement. A service area shall be approved if there is a sufficient number and type of providers adequate to meet the needs of the geographic area in addition to other requirements specified under Rules 59A-23.003, 59A-23.004, 59A-23.005, and 59A-23.006, F.A.C.

(6) Travel Times. Each application shall provide information which indicates the ability of the insurer or delegated entity to provide geographic access to health services for injured employees. Average travel time for injured employees from the employee's usual employment site to the nearest primary care delivery site and to the nearest general acute care hospital in the provider network shall be no longer than 30 minutes under normal circumstances. Average travel time from the employee's usual employment site to the nearest provider of specialty physician services, ancillary services, specialty inpatient hospital services and all other health services shall be no longer than 60 minutes under normal circumstances.

(7) Provider Network.

(a) Medical services shall be available for injured employees in the geographic area in which they are employed through directly or indirectly contracted network(s) of health care providers. The hours of operation and availability of after-hour care must reflect usual practices in the community and the insurer must demonstrate that:

1. All medically necessary services are available and accessible;

2. Medically necessary referrals are provided within the network or, if unavailable, outside the network;

3. There are written agreements describing specific delegated duties for provision of medical services.

Delegation of the provision of medical services by the insurer must be specifically described in the written agreement linking the insurer with the delegated entity;

4. Written agreements for arrangements in which the insurer is indirectly linked with a provider network shall contain language requiring the insurer's approval in advance of a change in the provider network; and

5. There are written agreements with providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any injured employee except as specified under Section 440.13, F.S.

(b) The insurer or delegated entity, shall establish and implement a policy and procedure regarding access to services which reflects usual and customary practices in the community and addresses access times for emergency, initial, and continuing care including referrals to specialty services.

(c) The agency shall examine provider networks at least annually. The insurer or delegated entity, shall file with the agency an updated list of providers by county, by specialty, semiannually. The list shall be submitted within six months of the initial network approval date and every six months thereafter in a format approved or prescribed by the agency.

(d) The insurer or delegated entity shall develop and implement a policy and procedure for credentialing and recredentialing network providers as needed, but at a minimum every two years. The credentialing criteria shall be specified in the policy and shall include the core credentialing data specified under paragraph 455.557(2)(d), F.S., and verification of education of providers as required by Section 440.134(8), F.S.

(e) The recredentialing process shall monitor and incorporate quality assurance findings and information on individual providers including sanctions, complaints and grievances, medical record audits, provider profiling, and employee satisfaction.

(f) If the insurer delegates all or part of the credentialing process to other organizations, the insurer shall specify the activities of the delegated entity and the oversight and reporting requirements in the written agreement. The insurer shall perform oversight of the delegated credentialing activities annually.

(g) 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. The medical care coordinator shall be licensed under Chapter 458 or 459, F.S., and be board certified by the American Board of Medical Specialties, or the American Osteopathic Association, or have two years experience as a participating provider in a workers' compensation managed care arrangement network. 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.

(h) Nothing in this rule prohibits the use by a medical or osteopathic physician of advanced registered nurse practitioners licensed under Section 464.012, F.S., or physician's assistants licensed under Chapter 458 or 459, F.S., in accordance with and within the scope of their professional licenses in Florida Statutes. An injured employee shall be evaluated or treated by the physician supervising the advanced registered nurse practitioner or physician assistant if specifically requested by the injured employee.

(i) 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 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.

(j) Initial and network change applications shall contain information on the numbers, types, and locations of health care providers which are included in the managed care network. The types of providers to be included shall comply with those listed on AHCA Form 3160-0005, November 2000, WCMCA Service Area Network Checklist, incorporated herein by reference. This form is available from the agency by contacting the Agency for Health Care Administration, Division of Managed Care and Health Quality, Bureau of Managed Health Care, 2727 Mahan Drive, Mail Stop 45, Tallahassee, Florida 32308.

(8) 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.

Specific Authority 440.134(25) FS. Law Implemented 120.57, 440.134(1)(g), (2)(a), (3), (4), (5), (6), (10), (12), (13), (14) FS. History--New 9-12-94, Amended 4-30-98, 5-8-01.

59A-23.004 Quality Assurance.

(1) 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.

(2) The scope of the quality assurance program shall include the following:

- (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.
- (3) 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:
- (a) Those specific activities under subsection (1) 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.
- (4) The insurer or delegated entity shall have a quality assurance committee that meets quarterly to review the progress of quality assurance activities, completion of the written work plan, findings, and to develop recommendations for corrective action and follow-up. The committee shall keep minutes of meetings to document the committee's activities. Activities of the committee shall include:
- (a) Identification of data to be collected;
 - (b) Evaluation of data collected;
 - (c) Recommendation of improvements utilizing data collected;
 - (d) Communication of the committee's findings to accountable authorities for implementation of improvements; and
 - (e) Evaluation and documentation of the results of the implementation of improvements.
- (5) 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.
- (6) 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.
- (7) 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. 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.
- (8) 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. The program shall evaluate quality of care and services, and provide review prospectively, concurrently, and retrospectively including pre-certification mechanisms for elective admissions and non-emergency surgeries.
- (a) The utilization management program shall ensure that:
 1. All elective admissions and non-emergency services must be precertified;
 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 consistency of the proposed treatment with the relevant standards;
 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;
 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;
 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;
 6. The utilization management program documents and communicates the reasons for each denial of requested medical services to treating providers and the injured employees;

7. The information obtained through the quality assurance program is considered in evaluating the timeliness and necessity of medical services;
8. There is a procedure for handling requests for experimental procedures;
9. There is a procedure for resolution of provider disputes regarding reimbursement and utilization review;
10. 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
11. There is a procedure for authorization of out-of-network services.

(b) Utilization management is responsible for:

1. Selection and application of nationally recognized review criteria and protocols;
2. Recommendation of general utilization management program policies;
3. Overall program monitoring; and
4. Review of all appeals of denials of requests for treatment or referrals.

(9) Case Management. The insurer or delegated entity shall develop and implement policies and procedures for aggressive medical care coordination, which may be provided via internal and external case management services in association with utilization management activities. The insurer or delegated entity shall specify the types and severity of injuries which require internal and external case management.

(a) 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.

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

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

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

(e) 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.

Specific Authority 440.134(25) FS. Law Implemented 440.134(6)(c)1.-8., 11., (7), (9), (10)(d), (11), (14)(a), (d), (15) FS. History--New 9-12-94, Amended 10-8-01, 1-22-02.

59A-23.005 Medical Records and Case Files.

(1) 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.

(2) 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. The insurer or delegated entity shall develop and implement policies and procedures that:

(a) 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;

(b) 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;

(c) Provide for the training and education of administrative staff and providers on medical record documentation, policies and procedures, storage and confidentiality of patient records;

(d) 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;

(e) Identify the patient as follows:

1. Name;
2. Social Security, alien identification number, or other identification number;
3. Date of Birth; Employer; home and work telephone numbers;
4. Sex; and
5. Date of work injury or illness.

(f) 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
11. Evidence of coordination of care and any injured employee non-compliance with treatment.

(g) 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 provisions of Section 440.134, F.S.; and

(h) 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.

(3) Case Files. The insurer or delegated entity shall maintain electronic or paper medical information necessary to ensure the efficient functioning of the care coordination process. The insurer or delegated entity shall develop and implement a policy and procedure that protects the confidentiality and security of case file information including the transfer and storage of paper and electronic information, and the handling of information on HIV, substance abuse, and mental health. Case files shall contain necessary information for the coordination of quality patient care between providers, insurers, employees, and employers including:

(a) The information from the notice of injury required by Section 440.13(4)(a), F.S.;

(b) The current primary care physician, primary care physician changes and the designated medical care coordinator;

(c) The treating physician's plan of care;

(d) Medical reports and information necessary to support the coordination of medical care;

(e) The injured employee's work status, work restrictions, date of maximum medical improvement, and permanent impairment ratings; and

(f) Efforts toward rehabilitation and reemployment of the injured employee.

(4) Audits of provider records. 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). 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. The insurer or delegated entity shall develop and implement an annual work plan for the medical record audits. The results of the audits shall be reported quarterly to the quality assurance committee and shall include the following:

(a) Number of physicians reviewed by county and by specialty;

(b) Areas where specific improvements in record keeping are indicated;

(c) Results from implementing improvements recommended in prior audits;

(d) Recommendations for education and feedback to providers; and

(e) Extent to which the physician's treatment plan was implemented.

Specific Authority 440.134(25) FS. Law Implemented 440.134(5)(c), (6)(c)1.-4., 8., (7), (8) FS. History--New 9-12-94, Amended 10-8-01, 1-22-02.

59A-23.006 Grievance Procedures.

- (1) Each insurer or delegated entity shall develop and implement a grievance procedure to resolve complaints and written grievances by employees and providers.
- (2) 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. A detailed description of the employee complaint and written grievance procedures shall be included in educational materials provided to injured employees. A detailed description of the provider complaint and grievance procedure shall be included in educational materials given to providers.
- (3) 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. 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 insurer or delegated entity shall not charge the employer, employee, or provider for administering the grievance process.
- (4) The grievance procedure shall include the following:
 - (a) Requests for services. The insurer or delegated entity shall implement a procedure to address initial requests for services. Initial requests for services, such as a request for medical services, second opinions, or a change in providers, are not considered a complaint or grievance. 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. 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.
 - (b) Complaint Procedure. 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.
 1. 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.
 2. 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. 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; and
 - (c) Written Grievance. 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. The procedure shall include notice to the employer when a grievance has been filed. 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.
 1. 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 shall be considered to have exhausted all managed care grievance procedures after three days from receipt.
 2. 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. 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.

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

4. 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 shall not preclude the employee from filing a request for assistance with the Division of Workers' Compensation relating to non-medical issues.

5. 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.

6. 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.

7. 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.

(5) 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.

(6) 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.

(7) The insurer or delegated entity shall provide a current mailing address in employee and provider educational materials that indicate where to file a grievance.

(8) 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.

(9) 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.

(10) 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.

(11) 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.

(12) 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.

(13) 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.

Specific Authority 440.134(25) FS. Law Implemented 440.134(1)(b), (d), (5)(c), (e), (6)(b), (c), (7), (8), (10)(c), (14)(d), (15) FS. History--New 9-12-94, Amended 10-8-01, 1-22-02.

59A-23.007 Examination by the Agency for Health Care Administration.

The agency shall conduct surveys within the first year of operation and no less than every two years thereafter, and shall conduct examinations, and investigate complaints regarding the quality of health care services being provided by workers' compensation managed care arrangements to ensure the health, safety and welfare of employees and to carry out the provisions of Section 440.134, F.S.

Specific Authority 440.134(2)(a) FS. Law Implemented 440.134(2)(a) FS. History--New 9-12-94.

59A-23.009 Education Procedures.

(1) Employee Education.

(a) 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:

1. 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 the workers' compensation managed care arrangement in a prominent location in the workplace;
2. Provision of detailed employee education materials about the requirements and limitations of the workers' compensation managed care arrangement to the injured employees; and
3. Ongoing education of employees about changes in the workers' compensation managed care arrangement.

(b) 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. 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.

(c) The insurer or delegated entity shall ensure that all injured employees are provided a current list of network providers within the service area in which the individual is employed. The insurer or delegated entity shall provide a copy of the list to the employee or designated representative within five calendar days of receipt of a request.

(2) Provider Education. The insurer or delegated entity shall ensure that the health care providers within the provider network have received training and education on the provisions of Chapter 440, F.S., and related administrative rules. 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.

(a) 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;
8. Dispute resolution and grievance procedures;
9. Communication procedures between managed care components;
10. Medical records and case file procedures;
11. Workers' compensation managed care statutes and regulations relating to remedial treatment; and
12. The health care provider's role in successful return to work.

(b) 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.

(c) 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.

(3) Administrative Staff Education. 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. 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;
- (h) Dispute resolution and grievance procedures;
- (i) Communication procedures between managed care components; and
- (j) Medical records and case files procedures.

Specific Authority 440.134(25) FS. Law Implemented 440.134(1)(b), (d), (g), (i), (j), (k), (3), (5)(a), (c), (e), (6)(b), (c)2., 3., 4., 6.-10., (7), (8), (10)(a)-(d), (11), (12), (14)(a)-(d), (15)(a)-(f), (17) FS. History—New 10-8-01.