# APPLICATION FOR WORKERS' COMPENSATION MANAGED CARE ARRANGEMENT

## I. APPLICATION INFORMATION

**Type of Application:**

Initial Authorization _____

Bi-annual Renewal of Authorization:
with changes _____
without changes _____

Authorization # _____

Service Area Addition/
Expansion Request _____

Amendment/change in the network or
plan of operation _____

## II. ORGANIZATION INFORMATION

**Type of Insurer/Carrier:**

Commercial Insurance Carrier _____
Assessable Mutual Insurer _____
Commercial Self Insured Fund _____
Group Self Insured Fund _____
Individual Self Insured Employer _____
Other _____

_____
Legal Name of Applicant

_____
Mailing Address

_____
City State Zip Telephone Number

_____
Contact Person Position Title Telephone Number

## Proposed Service Area:

| **Region 1** | | **Region 2** | | **Region 3** | | **Region 4** | | **Region 6** | |
|---|---|---|---|---|---|---|---|---|---|
| Escambia | _____ | Bay | _____ | Alachua | _____ | Baker | _____ | Hardee | _____ |
| Santa Rosa | _____ | Holmes | _____ | Bradford | _____ | Clay | _____ | Highlands | _____ |
| Okaloosa | _____ | Jackson | _____ | Citrus | _____ | Duval | _____ | Hillsborough | _____ |
| Walton | _____ | Washington | _____ | Columbia | _____ | Flagler | _____ | Manatee | _____ |
| | | Calhoun | _____ | Dixie | _____ | Nassau | _____ | Polk | _____ |
| | | Franklin | _____ | Gilchrist | _____ | St. Johns | _____ | | |
| | | Gadsden | _____ | Hamilton | _____ | Volusia | _____ | | |
| | | Gulf | _____ | Hernando | _____ | | | | |
| | | Jefferson | _____ | Lafayette | _____ | | | | |
| | | Leon | _____ | Lake | _____ | | | | |
| | | Liberty | _____ | Levy | _____ | | | | |
| | | Madison | _____ | Marion | _____ | **Region 5** | | | |
| | | Taylor | _____ | Putnam | _____ | Pinellas | _____ | | |
| | | Wakulla | _____ | Sumter | _____ | Pasco | _____ | | |
| | | | | Suwannee | _____ | | | | |
| | | | | Union | _____ | | | | |

| **Region 7** | | **Region 8** | | **Region 9** | | **Region 10** | | **Region 11** | |
|---|---|---|---|---|---|---|---|---|---|
| Brevard | _____ | Charlotte | _____ | Indian River | _____ | Broward | _____ | Dade | _____ |
| Orange | _____ | Collier | _____ | Martin | _____ | | | Monroe | _____ |
| Osceola | _____ | DeSoto | _____ | Okeechobee | _____ | | | | |
| Seminole | _____ | Glades | _____ | Palm Beach | _____ | | | | |
| | | Hendry | _____ | St. Lucie | _____ | | | | |
| | | Lee | _____ | | | | | | |
| | | Sarasota | _____ | | | | | | |

Is there a capitated contract with providers or a network to provide health services?

YES _____ NO _____

## SERVICE ARRANGEMENTS

Please provide information regarding which entities are performing the following services or functions of the WCMCA.

**If the WCMCA is using more than one unique arrangement of contracted entities, please attach a separate table for each distinct plan of operation.**

| TYPE OF SERVICE | NAME OF LEGAL ENTITY | BUSINESS ADDRESS | CONTACT AND TELEPHONE NUMBER |
|---|---|---|---|
| PROVIDER NETWORK<br>HMO _____<br>EPO _____<br>PPO _____<br>PHO _____<br><br>Owned _____<br>Leased _____ | | | |
| ADMINISTRATION OF MANAGED CARE SERVICES | | | |
| UTILIZATION REVIEW/ PEER REVIEW | | | |
| QUALITY ASSURANCE | | | |
| CASE MANAGEMENT | | | |
| GRIEVANCE/DISPUTE RESOLUTION | | | Grievance Coordinator: |

Does the WCMCA use a third party administrator (TPA) for any services other than those listed above such as bill payment, etc.?

YES _____ NO _____

(If yes, please identify the TPA(s) and indicate the type of services provided.

_____

_____

_____

## III. Application Filing Fee:

Amount Due: $1,000

CHECK NUMBER: _____

(Checks should be made payable to **Agency for Health Care Administration**
**2727 MAHAN DRIVE, MAIL STOP #26, TALLAHASSEE, FLORIDA 32308**

I certify the that I have been authorized by the governing body of the aforementioned insurer to file this application and that the information contained herein is, to the best of my knowledge, correct and accurate.

| | |
|---|---|
| Name (Please print) | Title |
| Signature | date |

## IV. ATTACHMENTS

Please attach a copy of the proposed managed care plan of operation for an initial application, addition to or amendment of the originally approved plan of operation, or for a renewal application if the plan of operation is significantly different from the original (e.g., a change in network provider arrangements, quality assurance, case management, utilization management, or dispute resolution procedures or arrangements). The proposed managed care plan of operation must include:

1. A statement providing a clear description of the service area or areas in which services will be provided.

2. A listing of health care providers included in the managed care arrangement by county, along with a copy of the signed contract between any provider network(s) or managed care organization and the insurer. The listing must include primary care physicians, specialists, hospitals, and ancillary services. A scale map of each service area indicating the general locations of primary care physicians or groups, specialists, and hospitals should be attached.

3. A description of the grievance procedure to be used which addresses the following:
   (a) 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.
   (b) The grievance procedure must be described in writing and provided to the affected workers and health care providers.
   (c) How, at the time the workers' compensation managed care arrangement is implemented, the insurer will provide detailed information to workers and health care providers describing how a grievance may be registered with the insurer.
   (d) How grievances will be considered in a timely manner and will be transmitted to appropriate decision makers within the managed care arrangement who have the authority to fully investigate the issue and take corrective action.
   (e) How if a grievance is found to be valid, corrective action will be taken promptly.
   (f) How all concerned parties must be notified of the results of a grievance.
   (g) 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.

4. 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:
   a. 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.
   b. 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.
   c. 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.
   d. A written plan, which includes ongoing review, for providing review of physicians and other licensed medical providers.
   e. Appropriate financial incentives to reduce service costs and utilization without sacrificing the quality of service.
   f. Adequate methods of peer review and utilization review. The utilization review process shall include a health care facilities precertification mechanism, including, but not limited to, all elective admissions and non emergency surgeries and should indicate the qualifications and ratio of utilization review personnel to workers or companies.
   g. Provisions for resolution of disputes arising between a health care provider and an insurer regarding reimbursements and utilization review.
   h. Availability of a process for aggressive medical care coordination (case management), 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.
   I. 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.

j. A provision for the selection of a primary care provider by the employee from among primary providers in the provider network.

k. The written information proposed to be used by the insurer to comply with subparagraph h.

l. An affidavit certifying that the providers listed under item 3 have been credentialed and contracted by the network(s).

5. 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.

6. Evidence that appropriate health care providers and administrative staff of the insurer's workers' compensation managed care arrangement have received training and education on the provisions of chapter 440 and the administrative rules that govern the provision of remedial treatment, care, and attendance of injured workers.

7. Written procedures and methods to prevent inappropriate or excessive treatment.

8. Written procedures and methods for the management of an injured workers' 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).

(c) 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.

(d) 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.

9. A description of the use of workers' compensation practice parameters for health care services when adopted by the agency.

10. A copy of informational materials to be provided to employees indicating 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.