By Senator Williams

4-1036-98

A bill to be entitled

An act relating to workers' compensation; amending s. 440.13, F.S.; providing that the fee schedules adopted under chapter 440, F.S., are the maximum fees allowed under a workers' compensation managed care arrangement; specifying circumstances under which an additional fee may be paid to a health care provider as part of a risk-sharing arrangement; revising requirements for the Agency for Health Care Administration in adopting practice parameters; amending s. 440.134, F.S.; providing definitions; prohibiting the agency from adopting rules that give a preference to any type of organization; providing additional procedures for handling informal and formal grievances; providing certain time limitations; requiring that a workers' compensation managed care arrangement notify its employees of the right to file a petition for benefits with the Division of Workers' Compensation of the Department of Labor and Employment Security; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsections (14) and (15) of section 440.13, Florida Statutes, are amended to read:

440.13 Medical services and supplies; penalty for violations; limitations.--

(14) PAYMENT OF MEDICAL FEES.--

(a) Except for emergency care treatment, fees for medical services are payable only to a health care provider certified and authorized to render remedial treatment, care, or attendance under this chapter. A health care provider may not collect or receive a fee from an injured employee within this state, except as otherwise provided by this chapter. Such providers have recourse against the employer or carrier for payment for services rendered in accordance with this chapter.

(b) Fees charged for remedial treatment, care, and attendance may not exceed the applicable fee schedules adopted under this chapter, which are the maximum reimbursements allowed under a workers' compensation managed care arrangement. However, the applicable fee schedule does not restrict the right of an insurer, self-insurance fund, individually self-insured employer, or assessable mutual insurer to agree to pay additional compensation to a health care provider as part of a contract that provides a risk-sharing arrangement between the insurer, self-insurance fund, individually self-insured employer, or assessable mutual insurer and the provider, or that provides any other incentive for successfully returning an injured employee to work.

(c) Notwithstanding any other provision of this chapter, following overall maximum medical improvement from an injury compensable under this chapter, the employee is obligated to pay a copayment of $10 per visit for medical services. The copayment does ~~shall~~ not apply to emergency care provided to the employee.

(15) PRACTICE PARAMETERS.--

(a) The Agency for Health Care Administration, in conjunction with the division and appropriate health professional associations and health-related organizations

shall ~~develop and may~~ adopt by rule ~~scientifically sound~~ practice parameters for medical procedures relevant to workers' compensation claimants, which must be prepared by nationally recognized health care institutions and professional organizations. Practice parameters developed under this section must focus on identifying effective remedial treatments and promoting the appropriate utilization of health care resources. Priority must be given to those procedures that involve the greatest utilization of resources either because they are the most costly or because they are the most frequently performed. Practice parameters for treatment of the 10 top procedures associated with workers' compensation injuries, including the remedial treatment of lower-back injuries, must be developed by December 31, 2000 ~~1994~~.

(b) The practice parameters ~~guidelines may be initially based on guidelines prepared by nationally recognized health care institutions and professional organizations but~~ should be tailored to meet the workers' compensation goal of returning employees to full employment as quickly as medically possible, taking into consideration outcomes data collected from managed care providers and any other inpatient and outpatient facilities serving workers' compensation claimants.

(c) Procedures must be instituted which provide for the periodic review and revision of practice parameters based on the latest outcomes data, research findings, technological advancements, and clinical experiences, at least once every 3 years.

(d) Practice parameters developed under this section must be used by carriers and the division in evaluating the

appropriateness and overutilization of medical services provided to injured employees.

Section 2. Subsections (1), (2), (15), and (18) of section 440.134, Florida Statutes, are amended to read:

440.134 Workers' compensation managed care arrangement.--

(1) As used in this section, the term:

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

(b) "Complaint" means any dissatisfaction expressed by an injured worker concerning an insurer's workers' compensation managed care arrangement.

(c) "Emergency care" means medical services as defined in chapter 395.

(d) "Informal grievance" means a verbal expression of dissatisfaction with care, services, or benefits, which is expressed by an injured employee or a provider, and which is addressed immediately, in person or by telephone, at the time the complaint is made known.

(e) "Formal grievance" means a written expression of dissatisfaction with care, services, or benefits, which is submitted by an injured employee or a provider, or which is submitted on behalf of an employee by an agent or a provider.

~~(d) "Grievance" means dissatisfaction with the medical care provided by an insurer's workers' compensation managed care arrangement health care providers, expressed in writing by an injured worker.~~

(f)~~(e)~~ "Insurer" means an insurance carrier, self-insurance fund, assessable mutual insurer, or individually self-insured employer.

(g)~~(f)~~ "Service area" means the agency-approved geographic area within which an insurer is authorized to offer a workers' compensation managed care arrangement.

(h)~~(g)~~ "Workers' compensation managed care arrangement" means an arrangement under which a provider of health care, a health care facility, a group of providers of health care, a group of providers of health care and health care facilities, an insurer that has an exclusive provider organization approved under s. 627.6472 or a health maintenance organization licensed under part I of chapter 641 has entered into a written agreement directly or indirectly with an insurer to provide and to manage appropriate remedial treatment, care, and attendance to injured workers in accordance with this chapter.

(i)~~(h)~~ "Capitated contract" means a contract in which an insurer pays directly or indirectly a fixed amount to a health care provider in exchange for the future rendering of medical services for covered expenses.

(j)~~(i)~~ "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 for evaluation or treatment. A medical care coordinator must ~~shall~~ be a physician licensed under chapter 458 or an osteopathic physician licensed under chapter 459. A medical case manager may also manage the medical care of an injured worker.

(k) "Medical case manager" means a qualified rehabilitative provider, as defined in s. 440.491, or a registered nurse licensed under chapter 464. A medical case

manager must act under the supervision of a medical care coordinator.

(l)~~(j)~~ "Provider network" means a comprehensive panel of health care providers and health care facilities who have contracted directly or indirectly with an insurer to provide appropriate remedial treatment, care, and attendance to injured workers in accordance with this chapter.

(m)~~(k)~~ "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 osteopathic physician 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.

(2)(a) The agency shall, beginning April 1, 1994, authorize an insurer to offer or utilize a workers' compensation managed care arrangement after the insurer files a completed application along with the payment of a $1,000 application fee, and upon the agency's being satisfied that the applicant has the ability to provide quality of care consistent with the prevailing professional standards of care and the insurer and its workers' compensation managed care arrangement otherwise meets the requirements of this section. Effective April 1, 1994, an ~~no~~ insurer may not offer or utilize a managed care arrangement without such authorization. The authorization, unless sooner suspended or revoked, ~~shall~~ automatically expires ~~expire~~ 2 years after the date of issuance unless renewed by the insurer. The authorization

shall be renewed upon application for renewal and payment of a renewal fee of $1,000, if ~~provided that~~ the insurer is in compliance with ~~the requirements of~~ this section and any rules adopted under this section ~~hereunder~~. In view of the fact that the Legislature has clearly expressed its intention that the Workers' Compensation Law be interpreted to facilitate returning an injured employee to work at a reasonable cost to the employer, and in order to encourage experimentation and the development of the most effective and cost-efficient means possible for returning an injured employee to work, the agency may not adopt rules that give a preference or advantage to any type of organization, such as a preferred provider organization, a health maintenance organization, or a similar entity.An application for renewal of the authorization must ~~shall~~ be made 90 days prior to expiration of the authorization, on forms provided by the agency. The renewal application may ~~shall~~ not require the resubmission of any documents previously filed with the agency if such documents have remained valid and unchanged since their original filing.

(b) Effective January 1, 1997, the employer shall, subject to the limitations specified elsewhere in this chapter, furnish to the employee solely through managed care arrangements such medically necessary remedial treatment, care, and attendance for such period as the nature of the injury or the process of recovery requires.

(15)(a) A workers' compensation managed care arrangement must have and use procedures for hearing complaints and resolving formal ~~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 in this section

~~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) An informal grievance must be concluded within 7 calendar days after it is initiated, unless the party who makes the complaint and the managed care arrangement mutually agree to extend the time for concluding the grievance procedure. The 7-day period commences upon contact by telephone or in person by the employee, provider, agency, or division. If the informal grievance remains unresolved after 7 days, the managed care arrangement shall notify the party making the complaint, in writing, of the results and of the right to activate a formal grievance procedure. The written notification must include the name, address, and telephone number of the contact person responsible for activating the formal grievance procedure. In addition, if an employee has made the complaint, the managed care arrangement shall advise the employee to contact the division's employee assistance office for additional information on the employee's rights and responsibilities and for information on the dispute resolution process under the Workers' Compensation Law.

(d) In order to ensure that the grievance procedure is not unduly delayed, the managed care grievance coordinator shall, within 3 business days after receiving a formal grievance, forward a copy of the formal grievance to the division's employee assistance office. A formal grievance must be concluded within 30 days after receipt by the managed care arrangement, unless the parties mutually agree to an extension. If the grievance involves collecting information

outside the service area, the managed care arrangement may extend the period by 15 calendar days. The managed care arrangement shall notify the employee in writing that additional information is required to complete review of the grievance and that a maximum of 45 days is allowed for this review. Within 5 business days after concluding a formal grievance, the managed care arrangement shall notify all parties of the results in writing.

(e) The managed care arrangement shall provide written notice to its employees and providers of the right to file a petition for benefits with the division upon completing the formal grievance procedure. Upon request, the managed care arrangement shall provide a copy of the final decision letter regarding a grievance to the division.

(f)~~(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.

(g)~~(d)~~ Grievances must be considered in a timely manner and must be transmitted to appropriate decisionmakers who have the authority to fully investigate the issue and take corrective action.

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

(i)~~(f)~~ All concerned parties must be notified of the results of a grievance.

(j)~~(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.

(18) The agency may suspend the authority of an insurer to offer a workers' compensation managed care arrangement or order compliance within 60 days, if it finds that:

(a) The insurer is in substantial violation of its contracts;

(b) The insurer is unable to fulfill its obligations under outstanding contracts entered into with its employers;

(c) The insurer knowingly utilizes a provider who is furnishing or has furnished health care services and who does not have an existing license or other authority to practice or furnish health care services in this state;

(d) The insurer no longer meets the requirements for the authorization as originally issued; or

(e) The insurer has violated any lawful rule or order of the agency or any provision of this section.

<u>The agency may not determine insurer compliance with this subsection by including any injury that requires medical treatment for which charges are incurred, but which does not disable the employee for more than 7 days, regardless of whether the injury is reported to the insurer.</u>

Section 3. This act shall take effect July 1, 1998.

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SENATE SUMMARY

Revises various provisions under which workers' compensation is paid under a managed care arrangement. Provides for maximum fees for remedial treatment, care, and attendance. Authorizes an insurer or self-insured employer to pay additional compensation to a health care provider as part of a risk-sharing arrangement. Requires that the Agency for Health Care Administration develop practice parameters for the 10 top procedures associated with workers' compensation injuries by December 31, 2000. Provides procedures and timeframes for filing informal grievances and formal grievances. Prohibits the Agency for Health Care Administration from considering certain injuries when determining whether to suspend an insurer's authority to offer a workers' compensation managed care arrangement.