By Representative Stabins

A bill to be entitled

An act relating to workers' compensation insurance; amending s. 440.02, F.S.; excluding certain injuries from the definition of "catastrophic injury"; amending s. 440.13, F.S.; authorizing insurers to pay certain amounts exceeding fee schedules under certain circumstances; requiring the Agency for Health Care Administration to adopt certain rules and to use certain national guidelines; amending s. 440.134, F.S.; providing additional definitions; providing for informal and formal grievances; providing procedures; providing requirements; prohibiting the agency from using certain information to determine insurer compliance under certain circumstances; providing an effective date.

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

Section 1. Subsection (34) of section 440.02, Florida Statutes, is amended to read:

440.02 Definitions.--When used in this chapter, unless the context clearly requires otherwise, the following terms shall have the following meanings:

(34) "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 that 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~~; or

(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~~.

Section 2. Paragraph (b) of subsection (14) and paragraph (a) of subsection (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.--

(b) Fees charged for remedial treatment, care, and attendance may not exceed the applicable fee schedules adopted under this chapter, which shall be the maximum reimbursement allowance under a workers' compensation managed care

arrangement. The applicable fee schedule shall not restrict the right of an insurer, self-insurance fund, individually self-insured employer, or assessable mutual insurer from agreeing to pay any additional compensation to any health care provider as part of a contract in which there is a risk sharing arrangement between the insurer, self-insurance fund, individually self-insured employer, or assessable mutual insurer and the provider or any other incentives for successful outcomes in returning an injured employee to work.

(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 guidelines, prepared by nationally recognized health care institutions and professional organizations, for ~~scientifically sound~~ practice parameters for medical procedures relevant to workers' compensation claimants. 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, 1999 ~~1994~~.

Section 3. Subsections (1), (2), and (15) of section 440.134, Florida Statutes, are amended, and subsection (25) is added to said section, 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)~~(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.

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

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

(e)~~(d)~~ "Formal grievance" means a written expression of dissatisfaction with the ~~medical~~ care, services, or benefits received which is submitted by a provider or an injured employee, or on an employee's behalf by an agent or provider and addressed through a dispute resolution process ~~provided by an insurer's workers' compensation managed care arrangement health care providers, expressed in writing by an injured worker~~.

(f) "Informal grievance" means a verbal complaint of dissatisfaction, expressed by an injured employee or a provider, with care services, or benefits received and addressed immediately through telephonic or personal interaction at the time the complaint is made known.

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

(h)~~(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 shall be a physician licensed under chapter 458 or an osteopathic physician licensed under chapter 459. The responsibilities for managing the medical care of an injured worker may be performed by a medical case manager.

(i) "Medical case manager" means a qualified rehabilitation provider as defined in s. 440.491 or a registered nurse licensed under chapter 464, either of whom act under the supervision of a medical care coordinator.

(j)~~(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.

(k)~~(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.

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

(m)~~(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.

(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, no insurer may offer or utilize a managed care arrangement without such authorization. The authorization, unless sooner suspended or revoked, shall automatically 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, provided that the insurer is in compliance with the requirements of this section and any rules adopted hereunder.

An application for renewal of the authorization shall be made 90 days prior to expiration of the authorization, on forms provided by the agency. The renewal application 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. Notwithstanding such requirement, any employer who self-insures pursuant to s. 440.38 may opt out of a mandatory managed care arrangement and the requirements of this section by providing such medically necessary remedial treatment, care, and attendance for such periods as the nature of the injury or process of recovery requires, as provided by s. 440.13. Nothing in this section shall be construed to prevent an employer who has self-insured pursuant to s. 440.38 from using managed care arrangements to provide treatment to employees of the employer.

(c) The agency shall not adopt any rule which gives a preference or advantage to any organization, including, but not limited to, a preferred provider organization, health maintenance organization, or similar entity, in order to encourage experimentation and development of the most effective and cost-efficient means possible for returning an injured employee to work.

(15)(a) A workers' compensation managed care arrangement must have and use formal and informal 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 decisionmakers who have the authority to fully investigate the issue and take corrective action.

(e) Informal grievances shall be concluded within 7 calendar days after initiation unless the parties and the managed care arrangement mutually agree to an extension. The 7-day period shall commence upon telephone or personal contact initiated by the employee or provider, the agency, or the division. If the informal grievance remains unresolved, the managed care arrangement shall notify the parties, in writing, of the results and shall advise them of their rights to initiate a formal grievance. The notification shall include the name, address, and telephone number of the contact person responsible for initiating the formal grievance. The managed care arrangement shall also advise the employee to contact the Employee Assistance Office for additional information regarding rights and responsibilities and the dispute resolution process under the Workers' Compensation Law. To ensure no undue delays in the dispute resolution process, the

managed care grievance coordinator shall, within 3 business days after receiving a formal grievance, forward a copy of the grievance to the division's Employee Assistance Office. A formal grievance shall be concluded within 30 days after receipt by the managed care arrangement unless the employee or provider and the managed care arrangement mutually agree to an extension. If the grievance involves the collection of information outside the service area, the managed care arrangement shall have 15 calendar days in addition to the 30-day period within which to process the grievance. 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 will be allowed for such review. Within 5 business days after conclusion of the review, the managed care arrangement shall notify the parties of the results of the review. 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 of Workers' Compensation of the Department of Labor and Employment Security upon completion of the formal grievance procedure. The managed care arrangement shall furnish a copy of the final decision letter from the managed care arrangement regarding the grievance to the division upon request.

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

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

(h)~~(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.

(25) Injuries which require medical treatment for which charges will be incurred whether or not such injuries are reported to the carrier, but which do not disable the employee for more than 7 days, shall not be used by the agency in determining insurer compliance with this section.

Section 4. This act shall take effect October 1 of the year in which enacted.

****

HOUSE SUMMARY

Revises various provisions of workers' compensation insurance, including modifying the definition of catastrophic injury; allowing insurers to exceed fee schedule amounts; providing for informal and formal grievances; prohibiting the Agency for Health Care Administration from prohibiting insurers from using alternative managed care arrangements; and allowing self-insureds to opt out of mandatory managed care arrangements. See bill for details.