By Representative Cosgrove

A bill to be entitled

An act relating to workers' compensation; amending s. 440.13, F.S.; providing for alternative medical care under certain circumstances; requiring the Agency for Health Care Administration to adopt guidelines for certain medical procedures; amending s. 440.134, F.S.; revising definitions; providing for informal and formal grievances; providing procedures; providing an additional criterion for agency suspension of certain insurer authority; authorizing certain insurers to opt out of mandatory managed care arrangements under certain circumstances; amending s. 440.191, F.S.; requiring employees to provide notice to certain persons or entities of alleged entitlement of benefits; providing an effective date.

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

Section 1. Paragraph (f) is added to subsection (2) of section 440.13, Florida Statutes, 1996 Supplement, and paragraph (a) of subsection (15) of said section is amended, to read:

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

(2) MEDICAL TREATMENT; DUTY OF EMPLOYER TO FURNISH.--

(f) If the employee is not enrolled in a managed care arrangement and requests alternative medical care, and the request is denied by the carrier, the employee must establish

by clear and convincing evidence that the alternative medical care in the same or another specialty is medically necessary. Alternative medical care for employees enrolled in a managed care arrangement shall be pursuant to such managed care arrangement.

(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, 1998 ~~1994~~.

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

(f)~~(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.

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

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

(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 osteopath licensed under chapter 459. The responsibilities for managing the medical care of an injured worker may be performed by a medical care manager.

(j) "Medical care manager" means a qualified rehabilitative 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.

(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, orthopedic practitioner, or internist physician licensed under chapter 458; a family practitioner, general practitioner, or internist osteopath licensed under chapter 459; a chiropractor licensed under chapter 460; a podiatrist licensed under chapter 461; an optometrist licensed under chapter 463; or a dentist licensed under chapter 466.

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

(n)~~(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. Due to the Legislature's clearly expressed intention that the workers' compensation law is to be interpreted to facilitate an injured worker's return to work at a reasonable cost to the employer, no rule shall be adopted by the agency which gives a preference or advantage to any type of organization, such as, but not limited to, a preferred provider organization, a health maintenance organization, or a 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.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 this paragraph, employers who self-insure pursuant to s. 440.38 may opt out of the mandatory managed care arrangements and 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 specified by s. 440.13. Nothing in this section shall be construed as to prevent an employer who has self-insured pursuant to s. 440.38 from using managed care arrangements to provide treatment to its employees if the employer so chooses.

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

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

(c) Informal grievances shall be initiated and concluded within 7 calendar days unless the parties and the managed care arrangement mutually agree to an extension. The 7-day period shall commence upon telephone or personal contact by the employee, the provider, the agency, or the division. If the informal grievance remains unresolved, the managed care arrangement shall notify the parties of the results in writing and advise the parties of their right to initiate a formal grievance. The written notification shall include the name, address, and telephone number of the contact person responsible for initiating a formal grievance. In addition, the managed care arrangement shall advise the employee to contact the Employee Assistance Office for additional information on rights and responsibilities and the dispute resolution process under the Florida Workers' Compensation Law.

(d) In order to ensure that there are no undue delays in the dispute resolution process, the managed care grievance coordinator shall, within 3 business days after initiation of a formal grievance, forward a copy of the formal grievance to the division's employee assistance office. For the purposes of this paragraph, the address of the division's employee assistance office shall be Post Office Box 8010, Tallahassee, Florida, 32314-8010. Formal grievances shall be initiated and concluded within 30 days after receipt of the notice 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 days set forth in this section to process the formal 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 providing such notice, the managed care arrangement shall notify the party of such requirements in writing.

(e) The managed care arrangement shall provide written notice to its employees and providers of the right to proceed under s. 440.191 with the Division of Workers' Compensation of the Department of Labor and Employment Security upon completion of the formal grievance procedure if the issues are not resolved by both parties. The managed care arrangement shall furnish a copy of the final decision letter from the managed care arrangement regarding the grievance to employer, carrier, and the Division of Workers' Compensation upon request.

(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.

Injuries which require medical treatment for which charges will be incurred, whether or not they are reported to the carrier, but which do not disable the employee for more than 7 days as a result of the injury shall not be used by the Agency for Health Care Administration in determining insurer compliance with this subsection.

Section 3. Paragraph (b) of subsection (2) of section 440.191, Florida Statutes, is amended, to read:

440.191 Employee Assistance and Ombudsman Office.--

(2)

(b) If at any time the employer or its carrier fails to provide benefits to which the employee believes he is entitled, the employee shall contact the office to request assistance in resolving the dispute. The employee shall simultaneously notify the employer, the employer's carrier, and the carrier's attorney if the carrier's attorney is known, in writing, of the benefits to which the employee believes he or she is entitled and for which he or she is requesting the assistance of the office.The office shall investigate the dispute and shall attempt to facilitate an agreement between the employee and the employer or carrier. The employee, the employer, and the carrier shall cooperate with the office and shall timely provide the office with any documents or other information that it may require in connection with its efforts under this section.

Section 4. This act shall take effect October 1, 1997.

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HOUSE SUMMARY

Provides for alternative medical care under managed care arrangements. Requires the Agency for Health Care Administration to adopt guidelines prepared by nationally recognized health care institutions and professional organizations for medical procedures relevant to workers' compensation claimants. Provides for informal and formal grievance procedures. Authorizes insurers to opt out of mandatory managed care arrangements. Requires employees to provide notice of alleged entitlement of benefits. See bill for details.