CHAPTER 6

NEW JERSEY WORKERS' COMPENSATION MANAGED CARE ORGANIZATIONS

Authority

N.J.S.A. 17:1C–6(e); 34:15–15 and 34:15–88.

Source and Effective Date

R.1993 d.346, effective July 6, 1993.
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Executive Order No. 66(1978) Expiration Date

Chapter 6, New Jersey Workers' Compensation Managed Care Organizations, expires on July 6, 1998.

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SUBCHAPTER 1. (RESERVED)

SUBCHAPTER 2. NEW JERSEY WORKERS' COMPENSATION MANAGED CARE ORGANIZATIONS

11:6–2.1 Purpose and scope

(a) The purpose of this subchapter is to encourage the use of managed care to furnish injured workers with such medical, surgical and other treatment, and hospital service, as shall be necessary to cure and relieve the worker of the effects of the injury and to contain medical costs under workers' compensation coverage by providing eligible employers with a method whereby they may select a managed care alternative to traditional workers' compensation medical care at a reduced premium.

(b) Nothing in this subchapter is intended to revise, rescind or replace any statute under the New Jersey Workers' Compensation Law (N.J.S.A. 34:15–1 et seq.) or any rules of the Division of Workers' Compensation promulgated thereunder.

(c) This subchapter applies to all persons subject to New Jersey's Workers' Compensation Law (N.J.S.A. 34:15–1 et seq.), to all insurers authorized to provide workers' compensation coverage in the State of New Jersey and to all entities seeking approval as a managed care organization under this subchapter.

11:6–2.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Approved managed care organization" means a managed care organization which has been approved by the Department in consultation with the Department of Health.

"Care coordinator physician" means a licensed physician employed by or under contract with, directly or indirectly, the managed care organization, and who is responsible for providing primary medical care to the injured worker, maintaining the continuity of the injured worker's medical care and initiating all referrals to other providers.

"Case manager" means an employee of the managed care organization who is either a licensed registered nurse or a licensed physician, designated to assume responsibility for coordination of services and continuity of care.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Compensation Rating and Inspection Bureau" or "CRIB" means the Bureau created, organized and supervised by the Commissioner of the New Jersey Department of Insurance in accordance with N.J.S.A. 34:15–1 et seq., the New Jersey Workers' Compensation Law.

"Department" means the New Jersey Department of Insurance.

"Employee" or "worker" means an individual covered under a policy of workers' compensation insurance issued pursuant to N.J.S.A. 34:15–1 et seq., the New Jersey Workers' Compensation Law.

"Employer" means an employer obligated under N.J.S.A. 34:15–1 et seq., the New Jersey Workers' Compensation Law, to provide to its employees workers' compensation insurance coverage.

"Insured" means any employer obligated under the New Jersey Workers' Compensation Law to be insured under a policy of workers' compensation insurance issued by an

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insurer authorized to write workers' compensation insurance in the State of New Jersey.

"Insurer" means any insurer authorized to write workers' compensation insurance in the State of New Jersey.

"Managed care organization" or "MCO" means any entity that manages the utilization of care and costs associated with claims covered by workers' compensation insurance, which may be approved by the Department in accordance with this subchapter.

"Medical director" means a licensed physician, board certified in occupational medicine, internal medicine, orthopedics, neurosurgery, neurology or related fields, having a minimum of three years experience in treating either trauma or work-related injuries or illnesses, who is employed by the MCO for the primary purpose of providing full-time, day-to-day direction, management and supervision of medical care.

"Medical service" means any medical, surgical, chiropractic, dental, hospital, nursing, ambulance, or related services or any medication, crutch, prosthesis, brace, support or physical restorative device.

"Medical service provider" or "provider" means any physician, hospital or other person or entity licensed or otherwise authorized by any state to furnish medical services.

"Participating physician" or "participating provider" means a health care physician or provider who is under contract, directly or indirectly, with a managed care organization.

"Physician" means a person duly licensed by the State of New Jersey or by any other state to practice one or more of the healing arts in that state within the limits of the license of the licentiate.

"Report" means medical information transmitted in written form containing relevant subjective and objective findings. Reports may take the form of brief or complete narrative reports, a treatment plan, a closing examination report, or any forms as prescribed by the Department or the Department of Health.

11:6–2.3 Approval of managed care organizations

(a) The completion by an MCO of the approval process conducted by the Department, in consultation with the Department of Health, under this subchapter shall authorize the approved MCO to provide medical services under a workers' compensation policy after the insurer has filed an application with CRIB to obtain approval of a minimum five percent overall premium reduction for the insured's election to use a Department-approved managed care system for workers' compensation medical coverage. An approval issued under this subchapter shall not be used for any purpose except as set forth in this subchapter.

(b) The approval issued to an MCO under this subchapter by the Department in consultation with the Department of Health shall remain in force for a period of two years excepting suspension or revocation pursuant to this subchapter.

11:6–2.4 Requirements of approved managed care organizations

(a) For purposes of providing medical services to injured workers under a workers' compensation insurance policy as set forth in this subchapter, an MCO shall meet the following criteria:

1. The MCO shall arrange for the full range of medical and rehabilitative services necessary to treat injured workers, including, but not limited to, primary care, orthopedic care, inpatient care, emergency care, physical therapy and occupational therapy. In the aggregate, services provided outside of the MCO network should not exceed 20 percent of the MCO's cost of medical and rehabilitative services provided to injured workers.

2. The MCO shall provide geographic access by county to emergency, medical and rehabilitative services for employer sites covered under its program. Such services may be delivered directly, under contract, or through written referral protocol;

3. The MCO shall have medical care direction provided and supported by medical directors as defined in this subchapter;

4. The MCO shall provide medical management, catastrophic case management, disability case management and monitoring. These case management services must be supported by documented medical and disability protocol and should be generally accepted by the medical community;

5. The MCO shall track and manage an injured worker's progress from the onset of injury through case resolution;

6. The MCO shall contract with participating health care and rehabilitation providers who are credentialed by the MCO according to their documented criteria, which must specifically include the provider's ability to handle workplace injuries and illnesses;

7. The MCO shall provide written dispute resolution and grievance procedures to assure that disagreements with medical providers are resolved without jeopardizing or disrupting patient management;

8. The MCO shall provide reports as may be required by the Commissioner in areas including, but not limited to, medical utilization, disability data and costs of the MCO;

9. The MCO shall possess the resources, financial and otherwise, necessary to sustain required services; and

10. The MCO shall have a fraud detection plan, which shall include, but not be limited to, measures for detecting and reporting instances of possible fraud on the part of injured workers, employers, medical providers and others. The MCO shall coordinate its fraud detection plan with the workers' compensation insurer's fraud prevention plan, where appropriate.

11:6–2.5 Managed care organizations approval procedures

(a) For purposes of obtaining the Commissioner's approval under this subchapter, an MCO shall submit two copies each of a written application to the Department and the Department of Health at the following addresses:

Managed Health Care Bureau
Actuarial Services, Life/Health
N.J. Department of Insurance
20 West State Street
CN 325
Trenton, NJ 08625

Alternative Health Systems Program
N.J. Department of Health
300 Whitehead Road
CN 367
Trenton, NJ 08625

(b) The MCO application shall include the following:

1. A list of the names, addresses, and specialities of the individuals, rehabilitation centers, hospitals and other centers and clinics that will provide services under the managed care plan. This list shall indicate which medical service providers will act as care coordinator physicians within the MCO. In addition, the MCO shall provide a map of the service area, indicating the location of the providers by type;

2. A narrative description of the places and protocol of providing services under the plan, including a description of the initial geographical service area. The geographical service area shall be designated as the county in which work sites are located; a description of the number and type of disciplines of medical service providers to treat work-related injuries and illnesses, such as orthopedic, chiropractic, dental and ophthalmologic services; and a description of the number of care coordinator physicians in the MCO. The MCO shall maintain an adequate number of care coordinator physicians to provide the level and quality of medical treatment and services as required under the Workers' Compensation Law. The requirements of this paragraph shall be met unless the MCO adequately demonstrates the unavailability of a particular type of provider in a particular geographic service area;

3. A description of the MCO treatment standards and protocols that will govern the medical treatment provided by all medical service providers, including care coordinator physicians. The number of providers should be adequate as necessary to ensure that workers of employers covered by the MCO can:

i. Receive emergency treatment as soon as practicable, preferably by a participating physician;

ii. Receive initial treatment by a participating physician within 72 hours (depending on the nature of the injury or illness) of the MCO's knowledge of the necessity or request for treatment;

iii. Receive initial treatment by a participating physician in the MCO within five working days or as soon thereafter as practicable, following treatment by a physician outside the MCO;

iv. Receive screening and treatment if necessary by an MCO physician in cases requiring in-patient hospitalization;

v. Be directed to medical service providers within a reasonable distance from the worker's place of employment, considering the nature of care required and normal patterns of travel. To receive urgent care, the worker shall be assigned to a physician near the workplace. The assigned care coordinator physician will, in turn, arrange for necessary care through a provider closer to the worker's residence, if appropriate;

vi. Receive treatment by a non-MCO medical service provider at the direction of the care coordinator physician when the worker resides outside the MCO's geographical service area. The care coordinator physician may only select a non-MCO provider who practices closer to the worker's residence than an MCO provider of the same category if that non-MCO provider agrees to the terms and conditions of the MCO; and

vii. Receive specialized medical services the MCO is not otherwise able to provide. The MCO's application shall include a description of the places and protocol of providing such specialized medical services;

4. Specimen copies of contract(s), agreement(s), or other documents between the MCO and each participating medical service provider representative, and executed copies of the signature page(s) of such contract, agreement or other document for each provider;

5. The identity of a communication liaison for the Department, employer, worker and the insurer at the MCO's location. The responsibilities of the liaison shall include, but not be limited to, responding to questions and providing direction regarding outgoing correspondence, medical bills, case management and medical services;

6. A description of the reimbursement procedures for all services provided in accordance with the MCO plan;

7. Satisfactory evidence of the MCO's ability to meet the financial requirements necessary to ensure delivery of service in accordance with the plan;

8. A description of the MCO's quality assurance program which shall include, but is not limited to:

i. A system for resolution and monitoring of problems and complaints, including, but not limited to, the problems and complaints of workers;

ii. A program which specifies the criteria and process for physician peer review; and

iii. A standardized claimant medical recordkeeping system designed to facilitate entry of information into computerized databases for purposes of quality assurance;

9. A program under the direction of a case manager involving cooperative efforts by the workers, the employer, the insurer, and the managed care organization to promote early return to work for injured workers;

10. A program which provides adequate methods of peer review and utilization review to prevent inappropriate or excessive treatment, including, but not limited to:

i. A pre-admission review program, which requires physicians to obtain prior approval from the MCO for all non-emergency admissions to the hospital and for all non-emergency surgeries prior to surgery being performed;

ii. Individual case management programs, which search for ways to provide appropriate care at lower cost for cases which are likely to prove very costly, such as physical rehabilitation or psychiatric care;

iii. Physician profile analysis which shall include such information as each physician's total charges; number and costs of related services provided; time loss of claimant; and total number of visits in relation to care provided by other physicians with the same diagnosis;

iv. Concurrent review programs, which periodically review the worker's care after treatment has begun, to determine if continued care is medically necessary;

v. Retrospective review programs, which examine the worker's care after treatment has ended, to determine if the treatment rendered was excessive or inappropriate; and

vi. Second surgical opinion programs which describe the worker's ability to obtain the opinion of a second physician when non-emergency surgery is recommended;

11. A procedure for internal dispute resolution, in coordination with the insurer, which shall include a method to resolve complaints by injured workers, medical providers and employers;

12. A description of the method whereby the MCO will provide insurers with information to inform employers of all medical service providers within the plan and the method whereby workers may be directed to those providers;

13. Copies of the MCO certificate of incorporation and/or by-laws indicating managed care responsibilities, if applicable;

14. A general diagram of the MCO's managed care organizational structure;

15. The location of the place of business where the MCO administers the plan and maintains its records;

16. Copies of executed contracts between the MCO and insurer, if applicable;

17. A listing and biography of the MCO's officers and directors, or the individuals within the MCO responsible for managed care;

18. Evidence of or the MCO's certification of malpractice insurance for each provider;

19. The MCO's most recently audited financial report or its capitalization and projections if a newly organized MCO;

20. A detailed description of the MCO's experience with the management of health care costs associated with workers' compensation claims and with other health care claims;

21. A copy of the certificate of the board certified medical director;

22. The estimated savings in overall medical costs expected from the use of the MCO and the methodology used in arriving at such estimate;

23. The outline of the operation of the MCO to be provided to employers explaining their rights and responsibilities; and

24. Any other materials specifically requested by the Commissioner or the Commissioner of Health in connection with a particular application.

(c) The materials specified in (b) above shall be retained by the Department and referred to the Department of Health for consultation as necessary. Any significant changes to the nature of the MCO's operations as reflected in these materials shall be reported to the Department within 30 days.

(d) The Department, in consultation with the Department of Health, shall review these documents and grant approval, within 45 days of the MCO's filing its application, to those MCOs deemed to meet the criteria set forth in this subchapter. The Commissioner may extend the 45–day time frame an additional 30 days for good cause shown and shall provide notice to the MCO of such extension. A decision to deny approval shall be accompanied by a written explanation by the Department of the reasons for denial.

(e) An approved MCO shall apply for renewal of its Department approval biannually.

11:6–2.6 Confidentiality of MCO application

(a) All data or information contained in the MCO's application for approval as set forth in N.J.A.C. 11:6–2.5(b) is confidential and will not be disclosed by the Department or the Department of Health to any person other than their employees and representatives, except the following items, but only upon written, specified request and upon notice to the MCO:

1. A description of the MCO's current and prior authority to do business in the State of New Jersey;

2. An organizational chart;

3. A listing and biography of the MCO's officers and directors;

4. The address of the MCO's place of business;

5. The identity of the MCO communication liaison;

6. MCO audited financial reports, capitalization or projections, if otherwise available as filed with any other state or Federal government agency; and

7. The certificate of MCO's board certified medical director.

11:6–2.7 Approval suspension and revocation

(a) The approval of an MCO issued by the Department under this subchapter may be suspended or revoked if:

1. The Department determines that the MCO criteria set forth in this subchapter are no longer being met;

2. Service under the plan is not being provided in accordance with the terms of the approved plan;

3. The plan for providing medical services fails to meet the requirements of these rules;

4. Any false or misleading information is submitted by the MCO or any member of the organization;

5. The approved MCO continues to utilize the services of a medical service provider whose license has been suspended or revoked by the licensing board; or

6. The approved MCO fails to reduce losses sufficiently to produce a five percent premium credit.

(b) If the Commissioner denies MCO approval under this subchapter or suspends or revokes MCO approval for any of the reasons set forth in this subsection, the MCO may request a hearing on the Commissioner's determination within 10 days from the date of receipt of such determination.

1. A request for a hearing shall be in writing and shall include:

i. The name, address and telephone number of a contact person familiar with the matter;

ii. A copy of the Commissioner's written determination;

iii. A statement requesting a hearing; and

iv. A concise statement describing the basis for which the MCO believes that the Commissioner's findings of fact are erroneous.

2. The Commissioner may, after receipt of a properly completed request for a hearing, provide an informal conference between the MCO and such personnel of the Department or Department of Health as the Commissioner may direct, to determine whether there are material issues of fact in dispute.

3. The Commissioner shall, within 30 days of a properly completed request for a hearing, determine whether the matter constitutes a contested case, pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq.

i. If the Commissioner finds that there are no good-faith disputed issues of material fact and the matter may be decided on the documents filed, the Commissioner shall notify the MCO in writing of the final disposition of the matter.

ii. If the Commissioner finds that the matter constitutes a contested case, the Commissioner shall transmit the matter to the Office of Administrative Law for a hearing consistent with the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

11:6–2.8 Monitoring; auditing

(a) The Department, together with the Department of Health, shall monitor and conduct periodic audits of the approved MCO as necessary to ensure compliance with the MCO approval criteria set forth in this subchapter.

(b) All records of the approved MCO and its individual participating physicians or providers shall be disclosed upon request of and in a format acceptable to the Commissioner. If such records are maintained in a coded or semi-coded manner, a legend for the codes shall be provided to the Commissioner.

11:6–2.9 Filing and review fees

(a) Every MCO filing for approval of its managed care program under the procedures set forth in N.J.A.C. 11:6–2.5 shall pay the following fees:

1. An approval application fee of $1,500 payable to "Department of Health."

2. A biannual approval renewal fee of $1,000 payable to "Department of Health."