CHAPTER 6

NEW JERSEY WORKERS' COMPENSATION MANAGED CARE ORGANIZATIONS

Authority

N.J.S.A. 17:1-8.1, 17:1-15e, 34:15-15 and 34:15-88.

Source and Effective Date

R.2009 d.191, effective May 18, 2009.
See: 40 N.J.R. 5950(a), 41 N.J.R. 2490(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1.c(2), Chapter 6, New Jersey Workers' Compensation Managed Care Organizations, expires on November 14, 2016. See: 48 N.J.R. 1049(a).

Chapter Historical Note

Chapter 6, New Jersey Workers' Compensation Managed Care Organizations, was adopted as R.1993 d.346, effective July 6, 1993. See: 25 N.J.R. 1330(a), 25 N.J.R. 2885(a).

Pursuant to Executive Order No. 66(1978), Chapter 6, New Jersey Workers' Compensation Managed Care Organizations, was readopted as R.1998 d.392, effective July 6, 1998. See: 30 N.J.R. 1747(b), 30 N.J.R. 2925(a).

Chapter 6, New Jersey Workers' Compensation Managed Care Organizations, was readopted as R.2004 d.41, effective December 23, 2003. See: 35 N.J.R. 3541(a), 36 N.J.R. 520(a).

Chapter 6, New Jersey Workers' Compensation Managed Care Organizations, was readopted as R.2009 d.191, effective May 18, 2009. See: Source and Effective Date. See, also, section annotations.

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 6, New Jersey Workers' Compensation Managed Care Organizations, was scheduled to expire on May 18, 2016. See: 43 N.J.R. 1203(a).

CHAPTER TABLE OF CONTENTS

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 workers' compensation managed care organization under this subchapter.

Amended by R.2004 d.41, effective January 20, 2004.
See: 35 N.J.R. 3541(a), 36 N.J.R. 520(a).
In (c), added "workers' compensation" preceding "managed care organization".

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:

"Affiliate" or "affiliated" means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with another person.

"Approved workers' compensation managed care organization" means a workers' compensation managed care organization which has been approved by the Department.

"Care coordinator physician" means a licensed physician employed by or under contract with, directly or indirectly, the workers' compensation 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 workers' compensation 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 Banking and Insurance.

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

"Department" means the Department of Banking and 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 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.

"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 illness, who is employed by the WCMCO 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 workers' compensation managed care organization.

"Person" means any natural person, corporation, association, partnership or other legal entity.

"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.

"Workers' compensation managed care organization" or "WCMCO" 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.

Amended by R.1998 d.392, effective August 3, 1998.
See: 30 N.J.R. 1747(b), 30 N.J.R. 2925(a).
Substituted references to the Department of Banking and Insurance for references to the Department of Banking throughout.
Amended by R.2004 d.41, effective January 20, 2004.
See: 35 N.J.R. 3541(a), 36 N.J.R. 520(a).
Added "Affiliate" or "affiliated", "Person" and "Workers' compensation managed care organization" or "WCMCO"; deleted "Managed care organization" or "MCO"; in "Approved workers' compensation managed care organization" and "Report", inserted "and Senior Services" following "Department of Health"; in "Medical director", substituted "WCMCO" for "MCO"; inserted "workers' compensation" preceding "managed care organization" throughout.
Amended by R.2009 d.191, effective June 15, 2009.
See: 40 N.J.R. 5950(a), 41 N.J.R. 2490(a).
In the introductory paragraph, inserted a comma following "subchapter"; in definition "Approved workers' compensation managed care organization", deleted "in consultation with the Department of Health and Senior Services" from the end; and in definition "Report", deleted "or the Department of Health and Senior Services" from the end.

11:6-2.3 Approval of workers' compensation managed care organizations

(a) The completion by a WCMCO of the approval process conducted by the Department under this subchapter shall authorize the approved WCMCO 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 a WCMCO under this subchapter by the Department shall continue in force excepting suspension, automatic expiration or revocation pursuant to this subchapter. If the WCMCO does not contract with any insurers during the initial two years of approval, the WCMCO's approval will automatically expire on the December 31st following the two-year anniversary of that initial approval.

Amended by R.2004 d.41, effective January 20, 2004.
See: 35 N.J.R. 3541(a), 36 N.J.R. 520(a).
Rewrote (b).

Amended by R.2009 d.191, effective June 15, 2009.
See: 40 N.J.R. 5950(a), 41 N.J.R. 2490(a).
In (a), deleted ", in consultation with the Department of Health and Senior Services," following the first occurrence of "Department"; and in (b), deleted "in consultation with the Department of Health and Senior Services" following "Department".

11:6-2.4 Requirements of approved workers' compensation managed care organizations

(a) WCMCOs shall submit an annual report by April 30th of each year to the Department of Banking and Insurance on a form provided by the Department which shall include income, expenses, gains or losses, number of new cases received since the prior report, number of claims submitted since the prior report, total provider charges, and total sums paid to providers. The annual report shall be submitted to the following address:

New Jersey Department of Banking and Insurance
Office of Life and Health Insurance
20 West State Street, 11th Floor
PO Box 325
Trenton, NJ 08625-0325

(b) The WCMCO shall report all changes in operations to the Department within 30 days of said change(s), including, but not limited to, contractual changes, name changes, mergers, acquisitions, sales of the WCMCO and/or the preferred provider organizations serving as the network or any changes at the address shown in (a) above.

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

1. The WCMCO 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 WCMCO network should not exceed 20 percent of the WCMCO's cost of medical and rehabilitative services provided to injured workers.

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

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

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

7. The WCMCO 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 WCMCO 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 WCMCO;

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

10. The WCMCO shall establish and implement a fraud detection plan in accordance with the provisions of N.J.A.C. 11:6-2.11;

11. The WCMCO shall establish and implement an early return-to-work program in accordance with the provisions of N.J.A.C. 11:6-2.13; and

12. The WCMCO shall establish and implement a peer and utilization review program and a utilization management program in accordance with the provisions of N.J.A.C. 11:6-2.14.

Amended by R.2004 d.41, effective January 20, 2004.
See: 35 N.J.R. 3541(a), 36 N.J.R. 520(a).
Rewrote the section.
Amended by R.2009 d.191, effective June 15, 2009.
See: 40 N.J.R. 5950(a), 41 N.J.R. 2490(a).
In the address in (a), substituted "Life and Health Insurance" for "Solvency Regulation" and inserted ", 11th floor"; and rewrote (b).

11:6-2.5 Workers' compensation managed care organization approval procedures

(a) For purposes of obtaining the Commissioner's approval under this subchapter, a WCMCO shall submit two copies of a written application to the Department of Banking and Insurance at the following address:

New Jersey Department of Banking and Insurance
Insurance Division/Office of Life and Health
20 West State Street—11th Floor
PO Box 325
Trenton, NJ 08625-0325

(b) The WCMCO application shall include the following:

1. Copies of the WCMCO basic organizational documents, which shall include the certificate of incorporation and/or by-laws indicating managed care responsibilities, if applicable;

2. A general diagram illustrating functional responsibilities within the WCMCO which shall also identify all subcontracted entities and the functions they perform;

3. An organizational chart reflecting all affiliated companies;

4. The location of the place of business where the WCMCO administers the plan and maintains its records;

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

6. The WCMCO's most recent audited financial report and the last three quarters unaudited financial reports, or its capitalization and projections if a newly organized WCMCO, as well as any other financial information required by N.J.A.C. 11:6-2.15;

7. A listing of the WCMCO's officers and directors and of the individuals within the WCMCO responsible for managed care, and a biographical affidavit for each or the NAIC biographical affidavit, which is incorporated herein by reference as amended and supplemented and is available at http:// www.naic.org/acaa/forms/forms.htm;

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

9. The identity of a communication liaison for the Department, employers, workers and the insurer at the WCMCO'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;

10. 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 counties 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 WCMCO. The WCMCO 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, N.J.S.A. 34:15-1 et seq. The requirements of this paragraph shall be met unless the WCMCO adequately demonstrates the unavailability of a particular type of provider in a particular geographic service area;

11. A list of the names, addresses and specialties of the individuals, providers, rehabilitation centers, hospitals and other facilities 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 WCMCO. In addition, the WCMCO shall provide a map of the service area, indicating the location of the providers by type;

12. Copies of specimen contracts and, when available, executed contracts between the WCMCO and insurer;

13. Copies of contracts and/or agreements between the WCMCO and any provider network subcontractors. Copies of executed signature page(s) of such contract, agreement or other document for each subcontractor shall be sent only upon request;

14. Specimen copies of provider contract(s), agreement(s) or other documents of a similar nature between the WCMCO or its subcontractors and each participating medical service provider or health care provider representative or subcontractor. Copies of executed signature page(s) of such contract, agreement or other document for each provider shall be sent only upon request. All provider agreements or amendments shall comply with the provisions or N.J.A.C. 11:6-2.10;

15. Evidence of or the WCMCO's certification of minimum malpractice insurance in the amount of $1,000,000/ $3,000,000 for each provider. For non-physician providers, self-insurance is acceptable subject to proof of adequate financial resources;

16. A description of the manner in which the WCMCO is compensated for its services, whether contracted directly with the employer or insurance carrier;

17. A description of the procedures for reimbursement to providers for all services provided in accordance with the WCMCO plan;

18. A description of the WCMCO 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 WCMCO are able to fulfill the requirements of N.J.A.C. 11:6-2.12;

19. A description of the WCMCO's quality assurance program, which shall comply with and include, but not be limited to, the following minimum requirements:

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;

20. A description of the WCMCO's program, under the direction of a case manager and involving cooperative efforts by the workers, the employer, the insurer, and the

workers' compensation managed care organization, to promote early return-to-work for injured workers in compliance with the minimum requirements for such programs set forth in N.J.A.C. 11:6-2.13;

21. A description of the WCMCO's peer review and utilization review programs in compliance with N.J.A.C. 11:6-2.14;

22. A description of the WCMCO's 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;

23. A description of the method whereby the WCMCO 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;

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

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

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

27. Any other materials specifically requested by the Commissioner in connection with a particular application.

(c) The materials specified in (b) above shall be retained by the Department. Any significant changes to the nature of the WCMCO's operations as reflected in these materials or changes to any items in (b) above, either during or after the approval process, shall be reported to the Department within 30 days.

(d) The Department shall review these documents and grant approval, within 60 days of the WCMCO's filing a complete application, to those WCMCOs deemed to meet the criteria set forth in this subchapter. The Commissioner may extend the 60-day time frame an additional 30 days for good cause shown and shall provide notice to the WCMCO of such extension. A decision to deny approval shall be accompanied by a written explanation by the Department of the reasons for denial.

Amended by R.1998 d.392, effective August 3, 1998.
See: 30 N.J.R. 1747(b), 30 N.J.R. 2925(a).
Rewrote (a); in (b), rewrote 3 and 4, substituted a reference to biographical affidavits for a reference to biographies in 17, substituted a reference to minimum malpractice insurance $1,000,000/3,000,000 for a reference to malpractice insurance in 18, inserted a reference to the last three quarters unaudited financial reports in 19, inserted a new 22, and recodified former 22 through 24 as 23 through 25; in (c), inserted "or changes to any items in (b) above, either during or after the approval process" in the second sentence; and in (e), added the last sentence in the introductory paragraph and 1 through 3.
Amended by R.2004 d.41, effective January 20, 2004.
See: 35 N.J.R. 3541(a), 36 N.J.R. 520(a).
Rewrote the section.
Amended by R.2009 d.191, effective June 15, 2009.
See: 40 N.J.R. 5950(a), 41 N.J.R. 2490(a).
In (a), rewrote the introductory paragraph and deleted the address for "New Jersey Department of Health and Senior Services"; in (b)13 and (b)14, deleted "to the Department of Health and Senior Services" following "sent"; in (b)27, deleted "or the Commissioner of Health and Senior Services" following "Commissioner"; in (c), deleted "and referred to the Department of Health and Senior Services for consultation as necessary" following the first occurrence of "Department" and inserted a comma following "process"; and in (d), deleted ", in consultation with the Department of Health and Senior Services," preceding "shall review".

11:6-2.6 Confidentiality of WCMCO application

(a) All data or information contained in a WCMCO's application for approval as set forth in N.J.A.C. 11:6-2.5(b) is confidential, not subject to disclosure under the Open Public Records Act, N.J.S.A. 47:1A-1 et seq., and will not be disclosed by the Department to any person other than their employees and representatives, except the following items:

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

2. An organizational chart;

3. A listing and biographical affidavit of the WCMCO's officers and directors;

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

5. The identity of the WCMCO's communication liaison;

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

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

Amended by R.2004 d.41, effective January 20, 2004.
See: 35 N.J.R. 3541(a), 36 N.J.R. 520(a).
In (a), rewrote the introductory paragraph and substituted "biographical affidavit" for "biography" in 3.
Amended by R.2009 d.191, effective June 15, 2009.
See: 40 N.J.R. 5950(a), 41 N.J.R. 2490(a).
In the introductory paragraph of (a), deleted "or Department of Health and Senior Services" following "Department".

11:6-2.7 Approval suspension and revocation

(a) The Commissioner shall approve an application if he or she finds that the applicant meets the following standards:

1. All of the materials required by this chapter or by the Commissioner have been filed;

2. The persons responsible for conducting the applicant's affairs are competent, trustworthy, possess good reputations, and have appropriate experience, training and education;

3. The applicant has demonstrated the ability to assure that its services will be performed in a manner which will ensure the efficient operation of its business, including appropriate financial controls;

4. The required programs to be used by the applicant are acceptable; and

5. The compensation arrangements made between the applicant and the benefits payer do not result in the assumption of financial risk by the applicant.

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

1. The Department determines that the WCMCO 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 WCMCO or any member of the organization;

5. The approved WCMCO 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 WCMCO fails to reduce losses sufficiently to produce a five percent premium credit.

(c) If the Commissioner denies WCMCO approval under this subchapter or suspends or revokes WCMCO approval for any of the reasons set forth in this subsection, the WCMCO 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 WCMCO 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 WCMCO and such personnel of the Department 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 WCMCO 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.

Amended by R.2004 d.41, effective January 20, 2004.
See: 35 N.J.R. 3541(a), 36 N.J.R. 520(a).
Added a new (a) and recodified former (a) and (b) as (b) and (c).
Amended by R.2009 d.191, effective June 15, 2009.
See: 40 N.J.R. 5950(a), 41 N.J.R. 2490(a).
In (c)2, deleted "or Department of Health and Senior Services" following "Department".

11:6-2.8 Monitoring; auditing

(a) The WCMCO will ensure that it will continuously meet the requirements of this subchapter and any amendments thereto.

(b) The Department shall monitor and conduct periodic audits of the approved WCMCO as necessary to ensure compliance with the WCMCO approval criteria set forth in this subchapter.

(c) All records of the approved WCMCO 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.

Amended by R.2004 d.41, effective January 20, 2004.
See: 35 N.J.R. 3541(a), 36 N.J.R. 520(a).
Added a new (a) and recodified former (a) and (b) as (b) and (c).
Amended by R.2009 d.191, effective June 15, 2009.
See: 40 N.J.R. 5950(a), 41 N.J.R. 2490(a).
In (b), deleted ", together with the Department of Health and Senior Services," following "Department".

11:6-2.9 Filing and review fees

Every WCMCO filing for approval of its managed care program under the procedures set forth in N.J.A.C. 11:6-2.5 shall pay a one-time non-refundable application fee of $3,000 payable to the "Department of Banking and Insurance." The fee shall be included with the application.

Amended by R.2004 d.41, effective January 20, 2004.
See: 35 N.J.R. 3541(a), 36 N.J.R. 520(a).
Rewrote (a).
Amended by R.2009 d.191, effective June 15, 2009.
See: 40 N.J.R. 5950(a), 41 N.J.R. 2490(a).
Rewrote the section.

11:6-2.10 WCMCO provider agreements

(a) No provider agreement or amendment thereto may be used until a copy of the form of agreement has first been filed with the Department of Banking and Insurance. Thereafter, the form of agreement may be used until or unless a disapproval is received from the Department.

(b) All forms of agreements and amendments shall be filed at least 60 days prior to the planned date of use, and shall include a unique identifying form number in the bottom left hand corner.

(c) Submission of amended forms of agreements shall include two copies of the amended agreement(s) or page(s) only, if practicable. One copy shall be marked to show changes from the prior form, and one copy shall be unmarked.

(d) Agreements with providers shall state:

1. The term of the agreement;

2. The services and supplies to be provided by the provider and a list of the contractual amounts or rates that will be paid to the provider for those services and supplies;

3. That providers shall not discriminate in their treatment of covered persons;

4. That the provider will hold the covered person harmless for the cost of any service or supply for which the carrier or intermediary provides benefits, whether or not the provider believes its compensation for the service or supply from the carrier or intermediary is made in accordance with the reimbursement provision of the provider agreement, or is otherwise inadequate; and

5. That the providers shall maintain malpractice insurance coverage in an amount not less than $1,000,000 per occurrence and $3,000,000 in the aggregate.

New Rule, R.2004 d.41, effective January 20, 2004.
See: 35 N.J.R. 3541(a), 36 N.J.R. 520(a).

11:6–2.11 WCMCO fraud detection plan

(a) The WCMCO shall establish and implement a comprehensive fraud detection plan for identifying and reporting instances of possible fraud on the part of injured workers, employers, medical providers and others.

(b) The WCMCO fraud detection plan shall consist of a written plan that is reviewed at least annually and revised as necessary, and which shall include, but not be limited to:

1. Identification of items that trigger investigation into fraud and abuse;

2. Identification of frequent fraud areas and methods for detecting fraud;

3. Mechanisms for receiving input on worker, employer and provider problems and concerns regarding fraud or abuse; and

4. Procedures for investigating and reporting suspected fraud.

(c) The WCMCO shall coordinate its fraud detection plan with the workers' compensation insurer's fraud prevention plan, where appropriate.

New Rule, R.2004 d.41, effective January 20, 2004.
See: 35 N.J.R. 3541(a), 36 N.J.R. 520(a).

11:6–2.12 Minimal WCMCO treatment standards and protocols

(a) The number of providers utilized by a WCMCO should be adequate to ensure that workers of employers covered by the WCMCO are able to receive, at a minimum, the following services:

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

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

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

4. 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;

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

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

7. Receive emergency treatment in accordance with procedures that provide that in a potentially life threatening condition, the 911 emergency response system should be called or the member should be taken to the nearest hospital emergency room. For fixed work sites, an WCMCO may instead submit alternative emergency treatment procedures that provide equivalent promptness of treatment and level of care.

New Rule, R.2004 d.41, effective January 20, 2004.
See: 35 N.J.R. 3541(a), 36 N.J.R. 520(a).

11:6–2.13 Early return-to-work program

(a) The WCMCO shall have an early return-to-work program to facilitate the return of an injured employee to the workplace in a timely manner. The program shall be coordinated by a case manager and be structured to ensure compliance with the provisions of the Americans With Disabilities Act, 42 U.S.C. §§ 12101 et seq.

(b) The Early Return-to-Work Program shall be based on a written plan which is reviewed annually and revised as necessary. The written plan shall include at a minimum:

1. The scope and purpose of the program;

2. Specification of back-to-work standards and procedures to facilitate an early return to work; and

3. Mechanisms to reduce the total claim costs of lost wages; medical costs; length of worker's disability; and lost work days.

(c) The WCMCO shall have a sufficient number of case workers to ensure that injured workers medically qualified for the Early Return–To–Work Program receive the following services:

1. Early initiation of direct contact with the injured employee, treating physician and employer;

2. Development of a return-to-work goal to include a treatment plan and anticipated return to work criteria;

3. Identification of factors that may interfere with the return-to-work goal;

4. Communication with the employer to ascertain availability of a transitional work assignment or modified work;

5. Coordination of job analysis and return-to-work goals with the treating physician and other health care providers as applicable;

6. Evaluation for vocational intervention if necessary; and

7. Follow-up with employee, physician and employer to ascertain compliance with treatment and vocational plans and overall success of case management.

New Rule, R.2004 d.41, effective January 20, 2004.
See: 35 N.J.R. 3541(a), 36 N.J.R. 520(a).

11:6–2.14 Peer and utilization review programs

(a) The WCMCO shall have a program providing adequate methods of peer review and utilization review to prevent inappropriate or excessive treatment which shall include, but not be limited to, the following:

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

2. 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;

3. Physician profile analysis, which shall include 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 to persons with the same diagnosis;

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

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

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

(b) The WCMCO shall have a utilization management program to monitor the appropriate utilization of health care services. The program shall be under the direction of the medical director or his or her physician designee. The utilization management program shall be based on a written plan that is reviewed at least annually by the WCMCO. The plan shall identify at least:

1. The scope of utilization management activities, including precertification, case management, concurrent review, retrospective review and second surgical opinion, if applicable;

2. Procedures to evaluate clinical necessity, access, appropriateness and efficiency of services;

3. Clinical review criteria and protocols used in decision-making;

4. Mechanisms to ensure consistent application of review criteria;

5. Qualifications of staff who render determinations to deny or limit an admission, service, procedure or extension of care;

6. A description of when and how utilization management staff may be reached;

7. The time frames for the various stages of the review process so as not to interfere with the provision of care;

8. The policy governing the second surgical opinion program, which describes the worker's ability to obtain the opinion of a second physician when non-emergency surgery is recommended;

9. Mechanisms for coordinating and communicating with the quality improvement program; and

10. Mechanisms to detect underutilization and overutilization of services.

(c) Utilization management criteria shall be based on current and generally accepted medical standards, developed with involvement from appropriate providers with current knowledge relevant to the criteria.

New Rule, R.2004 d.41, effective January 20, 2004.
See: 35 N.J.R. 3541(a), 36 N.J.R. 520(a).

11:6-2.15 Financial requirements for WCMCO

(a) In order to obtain initial approval, the WCMCO shall meet the following financial requirements:

1. A WCMCO applicant shall submit for approval an audited financial report for itself and all subcontracted entities for the year immediately preceding the application, completed on a generally accepted accounting principles (GAAP) basis, certified by an independent certified public accountant in accordance with N.J.A.C. 11:2-26.

2. If the financial affairs of the WCMCO'S parent company are audited on either a GAAP or statutory basis by an independent certified public accountant, but those of the WCMCO are not, then a copy of the audited financial statements of the parent company for the year immediately preceding the application may be submitted in lieu of the WCMCO filing audited financial statements.

3. The applicant shall submit for approval the following information with the audited financial report:

i. Disclosure of the source of all initial funding;

ii. Quarterly financial projections for the first three years of operations, which shall include a projected balance sheet, statement of revenue and expense, and statement of cash flows; and

iii. A description of the assumptions used in the financial projections which explain every major line item specifically and reasonably.

(b) The Commissioner may, upon reasonable notice, conduct a financial examination of a WCMCO as often as necessary in order to protect the interests of the residents of this state. The reasonable expenses of the examination shall be borne by the WCMCO being examined.

(c) For the purpose of conducting a financial examination of the WCMCO, the Commissioner may retain and employ such persons to conduct, or to assist in conducting the examination, as necessary.

(d) The WCMCO shall submit no later than June 1 of each year, audited annual financial reports for the immediately preceding calendar year on a GAAP basis certified by an independent certified public accountant in accordance with N.J.A.C. 11:2-26.

(e) If the financial affairs of the WCMCO'S parent company are audited on either a GAAP or statutory basis, by an independent certified public accountant, but those of the WCMCO are not, then a copy of the audited financial statements of the parent company for the immediately preceding year can be submitted in lieu of the WCMCO filing its audited financial statements.

(f) A copy of the audited annual reports shall be submitted to the following address:

Office of Solvency Regulation
New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, New Jersey 08625-0325

New Rule, R.2004 d.41, effective January 20, 2004.
See: 35 N.J.R. 3541(a), 36 N.J.R. 520(a).
Amended by R.2009 d.191, effective June 15, 2009.
See: 40 N.J.R. 5950(a), 41 N.J.R. 2490(a).
In the introductory paragraph of (f), substituted "A copy" for "Two copies".