INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

New Jersey Workers' Compensation
Managed Care Organizations

Proposed Readoption with Amendments: N.J.A.C. 11:6

Authorized By: Holly C. Bakke, Commissioner, Department of Banking and Insurance

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

Calendar requirements: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2003-317

Submit comments by October 3, 2003 to:

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The agency proposal follows:

Summary

The Department of Banking and Insurance (Department) proposes to readopt with amendment N.J.A.C. 11:6, New Jersey Workers' Compensation Managed Care Organizations. The expiration date of this chapter is January 2, 2004, pursuant to N.J.S.A. 52:14B-5.1c and N.J.A.C. 1:30-6.4(f). The Department has reviewed the current rules and has determined that they continue to be necessary, reasonable and proper for the purpose for which they were originally promulgated. The rules which are found in

Subchapter 2 provide a framework for encouraging the use of managed care to furnish injured workers with such medical, surgical and other treatments and hospital service as may be necessary to cure and relieve the worker of the effects of the injury. The framework further serves 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. The rules continue to be necessary to meet these ends.

In addition, the Department has determined that certain revisions to the rules are necessary for clarification and to further the purpose of the rules. Therefore, the Department proposes to amend the rules, propose new rules where necessary and to readopt the balance of the rules without amendment. Specifically, the Department proposes the following:

The Department proposes to add the words “workers’ compensation" to the phrase “managed care organization” throughout the rules to clarify that the rules in this chapter only apply to managed care organizations furnishing injured workers with services under workers’ compensation coverage. The new acronym for the organization is also being inserted throughout the regulation to reflect the change to workers’ compensation managed care organizations (WCMCO). In addition, the name of the Department of Health has been changed to the Department of Health and Senior Services throughout the chapter to reflect that Department’s name change.

N.J.A.C. 11:6-2.1 sets forth the purpose and scope of the chapter.

N.J.A.C. 11:6-2.2 sets forth the definitions of certain words and terms that appear in the chapter. Definitions have been added for “affiliate” or “affiliated” and “person” to

clarify what is meant by affiliated companies as used in the chapter. The definition of "managed care organization" is deleted and replaced with the definition of "workers compensation managed care organization."

N.J.A.C. 11:6-2.3 sets forth the effect and the duration of the approval given to WCMCOs by the Department in consultation with the Department of Health and Senior Services.

N.J.A.C. 11:6-2.3(b) has been amended to allow for the automatic expiration of WCMCO approvals that are not put to use within the first two years following the approval.

N.J.A.C. 11:6-2.4 sets forth the requirements a WCMCO must meet in order to provide medical services to injured workers under a workers' compensation policy.

New N.J.A.C. 11:6-2.4(a) is proposed to require an annual report on a form provided by the Department, which shall include the WCMCO's income, expenses, gains or losses; the number of new cases; the number of claims submitted to the WCMCO; the total provider charges; and the total sums paid to providers.

New N.J.A.C. 11:6-2.4(b) requires that the WCMCO report all changes in operations within 30 days including, but not limited to, contractual changes, name changes, mergers, acquisitions and sales of the WCMCO and/or the preferred provider organizations serving as the network.

Existing N.J.A.C. 11:6-2.4(a) is recodified as N.J.A.C. 11:6-2.4(c).

N.J.A.C. 11:6-2.4(c)10 is amended to clarify that WCMCOs must establish and implement a fraud detection plan, not merely possess such a plan. Two new paragraphs,

N.J.A.C. 11:6-2.4(c)11 and 12, are added to require that WCMCOs establish and implement a return-to-work program and a peer and utilization review program.

N.J.A.C. 11:6-2.5 sets forth the procedure on applications for approval as a WCMCO, as well as the required information and documentation which must accompany the application.

N.J.A.C. 11:6-2.5(a) is being amended to change the address to which applications for approval are to be submitted from the Managed Care Bureau to the Insurance Division/Office of Life and Health. The cross streets for the Department of Health and Senior Services, Market and Warren streets, are being added to that Department's address.

N.J.A.C. 11:6-2.5(b) has been amended and expanded to encompass new regulations and to recodify the current provisions into a coherent and more user-friendly order.

N.J.A.C. 11:6-2.5(b)1 clarifies that the required certificate of incorporation and/or bylaws are among the organizational documents that are to be sent with the application.

New N.J.A.C. 11:6-2.5(b)2 requires a general diagram of the WCMCO's structure including subcontractors.

New N.J.A.C. 11:6-2.5(b)3 requires an organizational chart, reflecting all affiliated companies.

N.J.A.C. 11:6-2.5(b)4 requires the specification of the location of the business where the WCMCO administers the plan and maintains its records.

N.J.A.C. 11:6-2.5(b)5 requires satisfactory evidence of the WCMCO's ability to meet the financial requirements necessary to ensure delivery of service in accordance with the managed care plan.

New N.J.A.C. 11:6-2.5(b)6 requires that the most recent audited financial report and last three quarters unaudited financial report, or its capitalization and projections if the WCMCO is newly organized, be submitted, and references the financial requirements in new N.J.A.C. 11:6-2.15.

New N.J.A.C. 11:6-2.5(b)7 requires that biographical affidavits for each of the WCMCO's officers and directors, and for the individuals within the WCMCO responsible for managed care, be submitted on the approved NAIC form, the NAIC biographical affidavit, which is incorporated by reference as amended and supplemented and which can be found on the NAIC website at http://www.naic.org/ucaa/forms/forms.htm.

N.J.A.C. 11:6-2.5(b)8 requires that the medical director be exclusive to only one WCMCO.

N.J.A.C. 11:6-2.5(b)9 requires the identification of a communication liaison for the Department, employers, workers and the insurer at the WCMCO's location and delineates the liaison's responsibilities. The responsibilities of the liaison include responding to questions and providing direction regarding outgoing correspondence, medical bills, case management and medical services.

N.J.A.C. 11:6-2.5(b)10 requires a narrative description of the places and protocol of providing services under the plan, including a description of the initial geographical service area, a description of the number and type of disciplines of medical service

providers and a description of the number of care coordinator physicians in the WCMCO. It further mandates that the WCMCO provide the level and quality of service required under the Workers' Compensation Law.

N.J.A.C. 11:6-2.5(b)11 requires a list of the names, addresses and specialties of the individual providers, rehabilitation centers, hospitals and other facilities that provide services under the managed care plan. The list must indicate which medical service providers will act as care coordinator physicians within the WCMCO, and the WMCO must provide a map of the service area indicating the location of the providers by type.

N.J.A.C. 11:6-2.5(b)12 requires specimen contracts and, when available, executed contracts between the WCMCO and the insurer.

N.J.A.C. 11:6-2.5(b)13 requires copies of the contracts and agreements between the WCMCO and any provider network subcontractors. A clarification is made stating that the required specimen contracts are provider contracts and that such documents must be supplied even if subcontractors are parties to the contracts. The former requirement for submission to the Department of Health and Senior Services of a copy of the executed signature pages is amended to require submission on request only.

In N.J.A.C. 11:6-2.5(b)14, the requirement for submission to the Department of Health and Senior Services of copies of the executed signature pages is amended to submission on request only, and a reference to a new and separate section on provider agreements is added.

N.J.A.C. 11:6-2.5(b)15 combines the former requirements of evidence of minimum malpractice insurance and the required minimum amount in one provision. The

paragraph also allows non-physician providers to self-insure with proof of adequate financial resources.

New N.J.A.C. 11:6-2.5(b)16 requires a description of the WCMCO's remuneration for services .

N.J.A.C. 11:6-2.5(b)17 requires a description of the procedures for reimbursement to providers for all services provided in accordance with the WCMCO plan.

N.J.A.C. 11:6-2.5(b)18 requires a description of the WCMCO treatment standards and protocols that will govern the medical treatment provided by all medical service providers. It mandates that an adequate number of providers be in place to ensure fulfillment of the requirements of N.J.A.C. 11:6-2.12.

N.J.A.C. 11:6-2.5(b)19 requires a description of the WCMCO's quality assurance program. It mandates that the minimum components of such program shall include: a system for resolution and monitoring of problems and complaints; a program which specifies the criteria and process for physician peer review; and a standardized claimant medical recordkeeping system.

N.J.A.C. 11:6-2.5(b)20 adds a reference to a separate section, N.J.A.C. 11:6-2.13, which contains the minimum requirements for an early return to work program.

N.J.A.C. 11:6-2.5(b)21 adds a reference to a separate section, N.J.A.C. 11:6-2.14, which contains the minimum requirements for peer and utilization review programs.

N.J.A.C. 11:6-2.5(b)22 requires a description of the WCMCO's procedure for internal dispute resolution.

N.J.A.C. 11:6-2.5(b)23 requires 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 by which workers may be directed to those providers.

N.J.A.C. 11:6-2.5(b)24 requires a detailed description of the WCMCO's experience with the management of health care costs associated with workers' compensation claims and with other health claims.

N.J.A.C. 11:6-2.5(b)25 requires the estimated savings in overall medical costs expected from the use of the WCMCO and the methodology used in arriving at that estimate.

N.J.A.C. 11:6-2.5(b)26 requires the outline of the operation of the WCMCO to be provided to employers explaining their rights and responsibilities.

N.J.A.C. 11:6-2.5(b)27 requires the submission of any other materials requested by the Commissioner in connection with a particular application.

N.J.A.C.11:6-2.5(c) continues to require WCMCOs to retain the documentation referenced in N.J.A.C. 11:6-2.5(b) and to report significant changes in the WCMCO's nature as reflected in those materials.

N.J.A.C. 11:6-2.5(d) is amended to increase the time for review and granting of approval of applications to 60 days and to clarify that the time for review commences upon the filing of a complete application.

N.J.A.C. 11:6-2.5(e), which required a biannual application for renewal, is deleted and has been replaced by the annual report requirement at N.J.A.C. 11:6-2.4(a).

N.J.A.C. 11:6-2.6 sets forth the principles of confidentiality for the data contained in the WCMCO application.

N.J.A.C. 11:6-2.6(a) limits the data or information contained in the WCMCO's application for approval which is held confidential to only information not subject to disclosure under the Open Public Records Act, N.J.S.A. 47-1A-1 et seq.

N.J.A.C. 11:6-2.6(a)3 is amended to reflect the change in submitted material from a biography to a biographical affidavit.

N.J.A.C. 11:6-2.7 sets forth the process for the suspension or revocation of approval by the Commissioner.

New N.J.A.C. 11:6-2.7(a) sets forth standards for approval of applications. All required materials must be filed with the Department. Persons responsible for conducting the applicant's affairs must be competent, trustworthy, possess good reputations and have appropriate experience, training and education. The applicant must demonstrate that its services will be performed in a manner which ensures the efficient operation of its business, including appropriate financial controls. The programs to be used by the applicant, which are required by this chapter, must be acceptable. The compensation arrangements between the applicant and the benefits payer can not result in the assumption of financial risk by the applicant.

Existing N.J.A.C. 11:6-2.7(a) and (b) are recodified as N.J.A.C. 11:6-2.7(b) and (c).

N.J.A.C. 11:6-2.8 sets forth requirements for the monitoring and auditing of WCMCOs.

New N.J.A.C. 11:6-2.8(a) is added requiring that WCMCOs ensure that they will continuously meet the requirements of the subchapter.

N.J.A.C. 11:6-2.8(a) and (b) are recodified as N.J.A.C. 11:6-2.8(b) and (c).

N.J.A.C. 11:6-2.9 sets forth the fees for approval of the WCMCO. The section is amended to remove the biannual renewal fee and to add a separate, one-time initial fee of $1,500 payable to Department of Banking and Insurance to the already existing one-time initial fee of $1,500 payable to the Department of Health and Senior Services.

New N.J.A.C. 11:6-2.10 sets forth the minimum requirements for provider agreements.

N.J.A.C. 11:6-2.10(a) requires that no provider agreement may be used until a copy of the form of agreement has been filed with the Department. After filing, the form may be used as long as no disapproval from the Department has been received.

N.J.A.C. 11:6-2.10(b) requires that all forms of agreement and amendments be filed at least 60 days before the planned date of use and contain a unique number in the bottom left hand corner with which it may be identified.

N.J.A.C. 11:6-2.10(c) requires two copies of amended forms to be filed: one unmarked and one marked showing the changes from the prior form of agreement.

N.J.A.C. 11:6-2.10(d) sets forth the minimum requirements for provider agreements. All agreements must state the term of the agreement, the services and supplies to be provided, and the benefits for which the provider will be paid by the carrier. The agreement also requires a non-discrimination clause and a hold harmless clause. Lastly, the agreement is required to state that providers shall maintain medical malpractice insurance of not less that $1,000,000 per occurrence and $3,000,000 in the aggregate.

New N.J.A.C. 11:6-2.11 sets forth the minimum standards for a fraud detection plan which must be implemented for identifying and reporting instances of possible fraud

on the part of injured workers, employers, medical providers and others. The rule requires a written plan that is reviewed at least annually and is revised as necessary. The plan shall include the identification of "red flag" items that trigger investigation into fraud and abuse; the identification of frequent fraud areas and methods for detecting fraud; mechanisms for receiving input on worker, employer and provider problems; and concerns and procedures for investigating and reporting suspected fraud. The rule also requires coordination with the workers' compensation insurer's fraud prevention plan where appropriate.

New N.J.A.C. 11:6-2.12 sets forth the minimum WCMCO treatment standards and protocols. Existing N.J.A.C. 11:6-2.5(b)3i through vii are reordered and relocated as N.J.A.C. 11:6-2.12(a)1 through 7.

N.J.A.C. 11:6-2.12(a)7 is expanded to specify minimum rules for emergency care or to allow an WCMCO to submit alternative procedures for fixed work sites, so long as those procedures provide equivalent promptness of service and level of care.

Although WCMCOs are already required to maintain an early return to work program by existing N.J.A.C. 11:6-2.5(b)9, the proposed relocation and amendment at new N.J.A.C. 11:6-2.13 adds minimum standards for these programs. The program shall be coordinated by a case manager and shall be structured to ensure compliance with the Americans With Disabilities Act, 42 U.S.C.A. §§ 12101 et. seq. The rule requires a written plan that is reviewed annually and revised as necessary. The written plan shall include the purpose and scope of the program; specifications of back-to-work standards and procedures, as well as mechanisms to reduce the total claim costs produced by lost wages, medical costs, length of disability and lost work days. The rule further

enumerates the various services to be made available to those injured workers who are medically qualified for an early return-to-work program, including: early contact; work goal development; identification of interfering factors; communication with employer; coordination with health care providers; evaluation for vocational intervention, if necessary, and follow-up with the employee, physician and employer to ascertain compliance and overall success.

New N.J.A.C. 11:6-2.14(a) relocates the minimum standards for methods of peer review and utilization review to prevent inappropriate or excessive treatment previously found at existing N.J.A.C. 11:6-2.5(b)10.

New N.J.A.C. 11:6-2.14(b) requires that WCMCOs have a utilization management program to monitor appropriate utilization of health care services. The program, which shall be under the direction of the medical director or his physician designee, shall be based on a written plan that is reviewed at least annually by the WCMCO. The written plan shall identify:

Scope of utilization management activities;

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

Clinical review criteria and protocols used in decision-making;

Mechanisms to ensure consistent application of review criteria;

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

Policy describing when and how utilization management staff may be reached;

Policy identifying the time frames for the various stages of the review process so as not to interfere with the provision of care;

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;

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

Mechanisms to detect underutilization and overutilization of services.

New N.J.A.C. 11:6-2.14(c) requires that utilization management criteria shall be based on current and generally accepted medical standards, developed with involvement from appropriate providers with current knowledge to the criteria.

New N.J.A.C. 11:6-2.15 sets forth the financial requirements for WCMCOs. N.J.A.C. 11:6-2.15 (a) sets forth the financial requirements for initial approval of the application of a WCMCO. The WCMCO shall submit for approval an audited financial report for itself, and all subcontracted entities for the year immediately preceding the application on a GAAP basis certified by an independent CPA. Non-audited WCMCOs with audited parent companies are required to submit the parent's audited financial statements. Information required in addition to the audited financial report includes disclosure of the source of all initial funding and quarterly financial projections for three years of operations. The rule further requires a description of the assumptions used in the financial projections, which explains every major line item specifically and reasonably.

N.J.A.C. 11:6-2.15(b) allows the Commissioner, upon reasonable notice, to conduct a financial examination of a WCMCO as often as deemed necessary to protect

the interests of the residents of this State. The subsection further requires that the WCMCO bear the reasonable costs of such examination.

N.J.A.C. 11:6-2.15(c) allows the Commissioner to retain and employ persons to conduct and assist in such financial examinations.

N.J.A.C. 11:6-2.15(d) requires each WCMCO to submit an audited, certified, annual financial report for the preceding year by no later than June 1 of each year.

N.J.A.C. 11:6-2.15(e) sets forth alternative instructions for non-audited WCMCOs with audited parent companies, requiring the submission of the parent's audited financial statements.

N.J.A.C. 11:6-2.15(f) sets forth the address to which WCMCOs must forward two copies of their audited annual reports.

A 60-day comment period is provided on this notice of proposal, and, therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, the proposal is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

The rules proposed for readoption should continue to have a positive effect on New Jersey WCMCOs, employees who use these organizations and their employers. The existing rules continues to set forth a framework for an alternative method of providing quality care to injured employees while allowing employers to reduce their costs.

The proposed amendments and new rules should have a positive effect on New Jersey WCMCOs, the employees who use these organizations, and their employers. The use of WCMCOs allows injured workers to receive prompt, appropriate, quality medical

care for compensable workplace injuries at a lower cost to insurers and employers. The clarification and addition of minimum standards for care and quality of WCMCO services will have a direct positive effect on workers by ensuring them prompt, appropriate and quality medical care. Employers will benefit from the minimum standards by being assured that their employees receive quality care. The clarification and addition of financial regulations and fraud prevention plans will help to ensure the financial integrity of the WCMCOs, which will benefit all those affected. The proposed amendments and readopted rules also continue to allow the Department to fulfill its regulatory duties, and enhance its ability to do so by providing clear and comprehensive guidelines.

Economic Impact

While there will be some negative economic impact on WCMCOs because of the continuing costs of compliance with the existing regulations, such as the continuing cost of maintaining malpractice insurance, and the compliance costs associated with record keeping and reporting, overall the readoption should have a favorable economic impact on New Jersey WCMCOs, the employees who use these organizations, and their employers. WCMCOs will continue to be able to offer workers compensation recipients their services and receive remuneration for those services. Injured workers will continue to receive quality care and their employers will continue to use this lower cost alternative to traditional workers' compensation insurance.

WCMCOs will be also be economically impacted by the amendments and new rules. The WCMCOs will experience increased costs of compliance due to the

establishment of new programs and the annual review of such programs. The WCMCOs will also experience increased costs due to the requirement to submit annual reports and audited financial reports, including the costs related to the certification of those reports by a CPA. New WCMCOs will also bear the cost of an additional application fee, and all WCMCOs will be responsible for the costs of any necessary financial examinations. However, WCMCOs will benefit from the elimination of the biannual renewal fee.

There should be little or no economic effect on workers or their employers as a result of these amendments and readopted rules. The Department does not believe that the proposed amendments will have any effect on the cost or availability of WCMCO coverage for employers. Although there will be some economic impact on WCMCOs resulting from the costs of compliance discussed above, the Department believes that the effect of those costs will be mitigated by the savings accrued from the elimination of the biannual fee, resulting in little or no change in the cost to employers. The Department anticipates that their adoption will not affect the monetary level of benefits available to workers.

Federal Standards Statement

A Federal standards analysis is not required because the rules proposed for readoption, new rules and amendments are not subject to any Federal requirements or standards.

Jobs Impact

The Department does not anticipate that the rules proposed for readoption, amendments and new rules will result in the generation or loss of jobs. The Department invites commenters to submit any data or studies concerning the jobs impact of the proposed amendments and new rules together with their written comments on other aspects of this proposal.

Agriculture Industry Impact

The Department does not expect any agriculture industry impact from the rules proposed for readoption, new rules and amendments.

Regulatory Flexibility Analysis

A regulatory flexibility analysis is required because some of the WCMCOs may be small businesses as defined in the New Jersey Regulatory Flexibility Act. See N.J.S.A. 52:14B-17. Reporting and compliance requirements, which affect all WCMCOs regardless of size, can be found in both the readoption and the amendments. See the Summary above for discussion of the reporting and compliance requirements and see the Economic Impact above for discussion on the costs of these requirements.

The rules proposed for readoption, new rules and amendments provide no different requirements specifically based on business size. Businesses of all sizes will be required to use professional services for compliance, such as the use of a CPA as discussed above. The rules proposed for readoption, new rules and amendments enforce a regulatory framework to ensure that WCMCOs meet minimum standards, while ensuring their financial viability and stability. This purpose does not provide for different

compliance requirements based on business size. Accordingly, the proposed amendments and readopted rules provide no differentiation in compliance based on business size.

Smart Growth Impact

The rules proposed for readoption, new rules and amendments have no impact on the achievement of smart growth and implementation of the State Development and Redevelopment Plan.

Full text of the readoption may be found in the New Jersey Administrative Code at N.J.A.C. 11:6.

Full text of the proposed amendments follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

11:6-2.1 Purpose and scope

(a) – (b) (No change)

(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.

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 in consultation with the Department of Health **and Senior Services**.

"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.

. . .

[" 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 illness, who is employed by the [MCO] **WCMCO** for the primary purpose of providing full-time, day-to-day direction, management and supervision of medical care.

. . .

"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.

. . .

"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 **and Senior Services**.

"**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.**

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

(a) The completion by [an MCO] **a WCMCO** of the approval process conducted by the Department, in consultation with the Department of Health **and Senior Services**, under this subchapter shall authorize the approved [MCO] **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 [an MCO] **a WCMCO** under this subchapter by the Department in consultation with the Department of Health **and Senior Services** shall [remain] **continue** in force [for a period of two years] 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.**

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. The annual report shall be submitted 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 Solvency Regulation

20 West State Street

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 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

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

1. The [MCO] **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 [MCO] **WCMCO** network should not exceed 20 percent of the [MCO's]

WCMCO's cost of medical and rehabilitative services provided to injured workers.

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

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

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

7. The [MCO] **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 [MCO] **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 [MCO] **WCMCO**;

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

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

11:6-2.5 [Managed] **Workers' compensation** managed care organization approval [and renewal] procedures

(a) For purposes of obtaining the Commissioner's approval under this subchapter, [an MCO] **a WCMCO** shall submit one copy of a written application to the Department of Banking and Insurance and one copy to the Department of Health and Senior Services at the following address**es**:

New Jersey Department of Banking and Insurance

[Managed Care Bureau]

Insurance Division/ Office of Life and Health [Division\

20 West State Street--11th Floor

PO Box 325

Trenton, NJ 08625-0325

New Jersey Department of Health and Senior Services

Office of Managed Care

John Fitch Plaza

Market and Warren Streets

PO Box 367

Trenton, NJ 08625

(b) The [MCO] **WCMCO** application shall include the following:

[1. A list of the names, addresses, and specialties 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 are able to do all of the following:

i. 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;

ii. 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;

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

iv. 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;

v. 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 terms and conditions of the MCO; and

vi. 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;

vii. 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 MCO may instead submit alternative emergency treatment procedures that provide equivalent promptness of treatment and level of care.

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

agreement, or other document for each provider shall be sent to the Department of Health and Senior Services. Provider contracts shall include the State- required malpractice insurance minimums of $1,000,000/$3,000,000.

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;

10. 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;

11. 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;

12. 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;

13. 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;

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

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

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

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

18. A listing and biographical affidavit of the MCO's officers and directors or the individuals within the MCO responsible for managed care;

19. Evidence of or the MCO's certification of minimum malpractice insurance $1,000,000/$3,000,000 for each provider;

20. The MCO's most recently audited financial report and the last three quarters unaudited financial reports or its capitalization and projections if 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. A description of the MCO's remuneration for service whether contracted directly with the employer or insurance carrier.

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

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

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

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 on the NAIC biographical affidavit, which is incorporated by reference as amended and supplemented, and is available at http://www.naic.org/ucaa/forms/forms.htm;

8. A copy of the certificate of the board certified medical director, who shall be exclusive to that WCMCO, and may not work as the medical director for any other similar entity;

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 to the Department of Health and Senior Services 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 to the Department of Health and Senior Services 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 or the Commissioner of Health and Senior Services in connection with a particular application.

(b) The materials specified in (b) above shall be retained by the Department and referred to the Department of Health and Senior Services for consultation as necessary. Any significant changes to the nature of the [MCO's] **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.

(c) The Department, in consultation with the Department of Health **and Senior Services**, shall review these documents and grant approval, within [45] **60** days of the [MCO's] **WCMCO's** filing [its] **a complete** application, to those [MCOs] **WCMCOs** deemed to meet the criteria set forth in this subchapter. The Commissioner may extend the [45-day] **60-day** time frame an additional 30 days for good cause shown and shall provide notice to the [MCO] **WCMCO** 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. For renewal, information required will be listed in the Workers' Compensation Managed Care Organization Renewal Package which includes:

1. A signed renewal affidavit;
2. A certificate of authority renewal request form; and
3. A summary of services provided.]

11:6-2.6 Confidentiality of [MCO] **WCMCO** application

(a) All data or information contained in [the MCO's] **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 or the Department of Health **and Senior Services** 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] **WCMCO's** current and prior authority to do business in the State of New Jersey;

2. An organizational chart;

3. A listing and [biography] **biographical affidavit** of the [MCO's] **WCMCO's** officers and directors;

4. The address of the [MCO's] **WCMCO's** place of business;

5. The identity of the [MCO] **WCMCO's** communication liaison;

6. [MCO] **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 [MCO's] **WCMCO's** board certified medical director.

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.

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

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

2. – 3. (No change)

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

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

[b] **(c)** If the Commissioner denies [MCO] **WCMCO** approval under this subchapter or suspends or revokes [MCO] **WCMCO** approval for any of the reasons set forth in this subsection, the [MCO] **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. – iii (No change)

iv. A concise statement describing the basis for which the [MCO] **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 [MCO] **WCMCO** and such personnel of the Department or Department of Health **and Senior Services** 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] **WCMCO** in writing of the final disposition of the matter.

ii. (No change)

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.

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

[(b)] **(c)** All records of the approved [MCO] **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.

11:6-2.9 Filing and review fees

(a) Every [MCO] **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 [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."]

one-time non-refundable application fees of $1,500 payable to the "Department of Health and Senior Services' and $1,500 payable to the "Department of Banking and Insurance." The fees shall be included with the application.

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 benefits that will be paid by the carrier;

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.

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.

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.

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.

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.

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 immediatly preceding year can be submitted in lieu of the WCMCO filing its audited financial statements.

(f) Two copies 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

inoregs/bgwcmag