INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

New Jersey Workers' Compensation
Managed Care Organizations

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

Proposed: August 4, 2003 at 35 N.J.R. 3541(a)

Adopted : December 23, 2003 by Holly C. Bakke, Commissioner, Department of Banking and Insurance

Filed: December 27, 2003 as R. 2004 d. 41,**with substantive changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

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

Effective Date: December 23, 2003, Readoption
January 20, 2004, Amendments

Expiration Date: December 23, 2008

Summary of Public Comments and Agency Responses:

The Department of Banking and Insurance received timely comments from three trade associations: New Jersey State Nurses Association; New Jersey Hospital Association; and American Insurance Association, and three New Jersey workers' compensation managed care organizations ("WCMCOs"): Horizon Blue Cross Blue Shield of New Jersey on behalf of Horizon Casualty Services, Inc.; Concerta Managed Care Services and New Jersey Manufacturers Insurance Group.

Comment: One commenter requested a modification in language that would add the words "advanced practice nurse" to those areas of the regulation which now use the word "physician," alone to describe a "care coordinator" who is employed by or under contract with a managed care organization.

Response: The Department disagrees that inclusion of "advanced practice nurse" to areas which now use the word "physician" is merely a language modification. This addition would constitute a substantive change which would require a new notice and comment period. Further, the Department is not prepared at this time to broaden the classification of providers who can serve as care coordinators to include

advance practice nurses. The Department intends to initiate further study on the feasibility of the use of advance practice nurses in the care coordinator function.

Comment: One commenter requested formal notification be provided to WCMCOs concerning the approval of a provider agreement or amendment as referenced in N.J.A.C. 11:6-2.10(a). Specifically, the commenter suggested that an approved agreement be stamped "Approved" and mailed back to the WCMCO for its files.

Response: The process of filing WCMCO provider agreements described at N.J.A.C. 11:6-2.10 is commonly referred to as "file and use." In contrast to a "prior approval" review process, the "file and use" process will allow a WCMCO to use a provider agreement at the end of a 60-day period, absent notice of disapproval by the Department. If, in the course of its review, the Department finds the form of agreement satisfactory, the Department intends to send a letter to the WCMCO, acknowledging that the form has been filed pursuant to N.J.A.C. 11:6-2.10.

Comment: One commenter requested clarification of N.J.A.C. 11:6-2.10(d), which requires a "list of benefits that will be paid by the carrier." The commenter asked whether the quoted text referred to the contractual rate for services and supplies provided.

Response: The commenter is correct. The regulation intended that the agreement delineate the amounts or rates that would be paid for the services and supplies mentioned in the agreement. The Department agrees that some clarification is needed, and will, upon adoption, replace the language "benefits that will be paid by the carrier" with “contractual amounts or rates that will be paid to the provider for those services and supplies."

Comment: One commenter urged that WCMCOs not be required to report or submit detailed information and materials not required under the current rules, as they were unaware of any problems or issues arising in New Jersey which demonstrate the need for these requirements.

Response: The detailed information to which the commenter objected is the information identifying affiliates, the biographies of the officers and directors, and copies of all a WCMCO's network contracts

and agreements. This information is already required on the current application. Thus, the provision in question is simply a codification of a current practice. The Department believes that the information is necessary to assure the competence and expertise of the directors and officers of a WCMCO, and to allow the Department to fully understand how care will be provided and by whom.

Comment: One commenter urged that the prohibition against a medical director working with more than one WCMCO be deleted, as the requirement would likely represent a considerable financial burden for smaller WCMCOs.

Response: After consideration, the Department has decided not to adopt the proposed prohibition at this time, in order to allow time for further study.

Comment: One commenter was concerned that the rules limit a WCMCO's ability to offer specialized services which are designed to meet the unique needs of carriers, employers and workers by specifying in detail the composition and operation of early return-to-work programs and utilization review activities.

Response: The Department disagrees with the comment, and believes that there is sufficient flexibility in the rules to permit a WCMCO to offer specialized services designed to meet the unique needs of carriers, employers and workers.

Comment: N.J.A.C. 11:6-2.13(a) provides that early return-to-work programs are required to be structured in order to ensure compliance with the provisions of the Americans with Disabilities Act (ADA). One commenter requested that the Department clarify the specific provisions of the ADA that are intended to apply to WCMCOs.

Response: The intention of this rule was not to specify Federal provisions but to bring to the attention of WCMCOs the requirement that any early return-to-work program which they design needs to comply with the Americans with Disabilities Act.

Comment: One commenter stated that the proposed January 2, 2004 effective date of the proposed amendments does not provide an appropriate timeframe during which organizations that have been

previously approved as managed care organizations (MCOs) will be able to transition to WCMCO status. The commenter asked that a transition period be allowed where MCO status remains in effect to allow approved MCOs to prepare and submit application materials.

Response: The Department believes that the commenter is under a misapprehension that the rule is changing the status of managed care organizations to workers' compensation managed care organizations. The change within the chapter from MCOs to WCMCOs was simply a clarification of the existing rule. The existing chapter, New Jersey Workers' Compensation Managed Care Organizations, defined an MCO as "any entity that manages the utilization of care and costs associated with the claims covered by workers' compensation insurance, which may be approved by the Department in accordance with this subchapter." The change in the rules from the acronym MCO to WCMCO emphasizes the exclusive nature of the WCMCO. An MCO which has been approved by the Department in accordance with the subchapter is and always has been a WCMCO. It should also be noted that WCMCOs which have already been approved in accordance with the subchapter are not required to prepare and submit applications.

Comment: One commenter recommended that the regulations be amended to require medical directors to hold medical licenses issued by the State of New Jersey.

Response: The Department disagrees. The Department believes that a regulation requiring that medical directors hold New Jersey medical licenses in addition to holding a medical license in another state would be too restrictive on workers' compensation managed care entities based in other states.

Comment: One commenter requested clarification of the meaning of a "participating physician" or "participating provider" being under contract "directly or indirectly" as used in N.J.A.C. 11:6-2.2.

Response: When a WCMCO is under contract "directly," a contract exists between the provider and the WCMCO without any other entities positioned between the two contracting parties. When a WCMCO is under contract "indirectly," a contractual relationship exists with one or more entities between the provider and the WCMCO. For example, the provider has a contractual relationship with a subcontractor, who in turn has a contractual relationship with the WCMCO.

Comment: N.J.A.C. 11:6-2.4(c)12 references the establishment and implementation of a utilization review program. The commenter believes that the Department should be holding WCMCOs to the same utilization standards as those established for health maintenance organizations by the Department of Health and Senior Services under N.J.A.C. 8:38. The commenter questioned why the Department is not requiring WCMCOs to utilize the standards developed by the Department of Health and Senior Services (DHSS) regarding quality assurance in N.J.A.C. 11:6-2.5(a)19I through iii. The commenter noted that every other managed care organization in the State is held to the DHSS standards.

Response: The Department disagrees. The Department created these rules with the cooperation and assistance of the DHSS, which gave specific input with respect to the utilization management review programs and quality assurance standards. Moreover, it is not entirely accurate that every other managed care organization in the State is held to the DHSS standards; not all entities engaged in the provision of managed care services are within the scope of the jurisdiction of the DHSS rules. Furthermore, the utilization management standards applicable to the various entities that are subject to the jurisdiction of the DHSS rules are not entirely uniform; some consideration is given to the types of services being provided by the various entities, as well as the types of “insurance” products to which the services relate. Although there are similarities in the services being performed by WCMCOs with at least some other types of entities that provide either benefits or services related to health benefits plans, there are differences as well. WCMCOs are not held to the same standards as other entities associated with providing the services for, or the administration of, health benefits plans in the State because of the unique nature of work place injuries and the workers' compensation system.

Comment: N.J.A.C. 11:6-2.5(b)10 requires that a WCMCO maintain an "adequate" number of care coordinator physicians to provide a specified level and quality of service. One commenter pointed out that terms such as "adequate" are not defined and are therefore left open to interpretation.

Response: The Department believes that the number of physicians necessary will vary on a "case-by-case" basis, and the use of the term "adequate" allows latitude for variables such as the nature of the

industries covered. Further, the Workers' Compensation Law provides the standards for the level and quality of service.

Comment: N.J.A.C. 11:6-2.5(b)22 requires a WCMCO to establish a procedure for internal dispute resolution. A commenter inquired as to whether this procedure applies to the payment of claims, and, if so, whether the WCMCO must utilize the dispute resolution process established at N.J.A.C. 11:22-1.

Response: The procedure for internal dispute resolution required by N.J.A.C. 11:16-2.5(b)22 is not specifically for disputes involving claims. The procedure is for any internal disputes arising from the use of the WCMCO, including disputes regarding the payment of claims.

N.J.A.C. 11:22-1 applies to carriers offering "health benefits plans," which is a statutorily-defined term. The policies with which WCMCOs are associated are not health benefits plans. WCMCOs may design a dispute resolution mechanism that is consistent with the general requirements of N.J.A.C. 11:22-1.2, to the extent feasible, but the WCMCO is not compelled to do so. As noted above, because the dispute resolution mechanism required by N.J.A.C. 11:6-2.5(b)22 is not intended solely to address claims issues, the dispute resolution mechanism would have to be designed to facilitate the resolution of a wider range of topics. Certain requirements of N.J.A.C. 11:22-1 that are essentially claim specific will have little or no utility in resolving other types of disputes.

Comment: N.J.A.C. 11:6-2.12(a)7 requires that emergency care be provided in potentially life threatening conditions. A commenter asked if the Department is applying the prudent lay person definition to dictate how "life threatening" can be determined. The commenter points out that this definition has been incorporated into N.J.A.C. 8:38 and 8:38A.

Response: The Department has not defined "life-threatening," nor proposed any specific standard for determining what is "life-threatening." The Department believes the plain meaning of the words is sufficient.

The prudent lay person standard found at N.J.A.C. 8:38-1.2 and 8:38A-1.2 applies not to the word "life-threatening," but to the word "emergency," which includes situations that are life-threatening as well as other situations that do not rise to the level of life-threatening.

The Department will monitor this issue and possibly address this concern in a future rule proposal.

Comment: One commenter stated that N.J.A.C. 11:6-2.14(a) requires a WCMCO to have a program that provides "adequate" methods of peer review and utilization review. They questioned how "adequate" was to be defined, stating that it was a vague term which would lead to conflicting interpretation.

Response: The Department does not believe that adequate is a "vague term" when used in the context of N.J.A.C. 11:6-2.14, since minimum standards for the types of review programs and the objectives of each type of program are included in the rule.

Comment: N.J.A.C. 11:6-2.14(a)1 requires a pre-admission program, with physicians obtaining prior approval for non-emergent admissions and for non-emergent surgeries. One commenter pointed out that the proposed rule does not define timeframes within which the WCMCO must respond to these requests. However, the Department's personal injury protection (PIP) regulations include timeframes for pre-authorization.

Response: The Department acknowledges that there are timeframes for the pre-authorizations in the "PIP" rules. However, timeframes for preauthorizations are not specified in all Department rules. The Department believes that the unique nature and structure of the workers' compensation system, including the use of case managers, provides sufficient safeguards for a worker seeking preauthorization.

Comment: N.J.A.C. 11:6-2.14(a)5 references retrospective review programs. One commenter would like the Department to clarify that, "although a retrospective review may be conducted, retrospective denial of care is prohibited as it is under current HMO regulations at N.J.A.C. 8:38." In addition, the commenter felt there was little need for retrospective review as the concurrent review, which is also required, has the same objective of ensuring that care is neither excessive nor inappropriate.

Response: The retrospective review programs required pursuant to N.J.A.C. 11:6-2.14(a) function more as an audit mechanism to see if the treatment taken as a whole was excessive or inappropriate. There is

no retrospective denial of claims involved in this process, though the retrospective review programs might result in changes in policies and procedures going forward.

Comment: N.J.A.C. 11:6-2.14(c) requires that the criteria for utilization management be based on medical standards. One commenter requested that WCMCOs be required to supply providers with those criteria.

Response: The Department agrees that the commenter's suggestion is a good one and worthy of consideration. However, such a proposed change cannot occur upon adoption, as it constitutes a substantive change that requires a new notice and comment period. The Department will reconsider the issue the next time that amendments are proposed to the chapter.

Comment: One commenter noted the proposed replacement of the biannual renewal application requirement with an annual reporting requirement. The commenter appreciated the Department's efforts, finding the proposed rule more reasonable, far less burdensome, and consistent with the State's efforts to reduce paperwork and duplicative reports.

Response: The Department thanks the commenter for its support.

Comment: Another commenter found the timing of the adoption problematic. As their renewal application was due shortly, the commenter asked to be able to act in a manner consistent with the proposal. They requested the Department suspend the renewal application requirement indefinitely and direct all companies to file an annual report due April 30, 2004. Alternatively, they asked for a four-month grace period for the filing of a renewal application in order to provide sufficient time for preparation.

Response: The Department acknowledges that the timing of the proposal is problematic, and is prepared to grant extensions to affected parties, if necessary, upon request.

Federal Standards Statement

A Federal standards analysis is not required because the rules readopted with amendments are not subject to any Federal requirements or standards.

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

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

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

(a) (No change from proposal.)

(b) The WCMCO application shall include the following:

1. - 7. (No change from proposal.)

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. - 27. (No change from proposal.)

(c) -(d) (No change from proposal.)

11:6-2.10 WCMCO provider agreements

(a) - (c) (No change from proposal.)

(d) Agreements with providers shall state:

1. (No change from proposal.)

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

3. - 5. (No change.)