

**TITLE 85  
EXEMPT LEGISLATIVE RULE  
WORKERS' COMPENSATION COMMISSION**

**SERIES 21  
MANAGED HEALTH CARE PLANS**

**§85-21-1. General.**

1.1. Scope. -- This exempt legislative rule establishes the requirements and procedures to be followed by the West Virginia Workers' Compensation Commission, parties to claims pending before the Commission, employers, private carriers, and managed health care plan administrators and others involved in the delivery or proposed delivery of managed care to injured workers pursuant to W. Va. Code §§23-4-3(b)(2) and 23-2C-17(d)(1) and (2).

1.2. Authority. -- W. Va. Code §23-4-3(b)(2). Pursuant to W. Va. Code Section §23-1-1a(j)(3), rules adopted by the Workers Compensation Board of Managers are not subject to legislative approval as would otherwise be required under W. Va. Code Section §29A-3-1 et seq. Public notice requirements of that chapter and article, however, must be followed. Upon termination of the Commission, regulatory enforcement of this exempt legislative rule shall transfer to the Insurance Commissioner. W. Va. Code §23-2C-22.

1.3. Filing Date. -- June 29, 2005.

1.4. Effective Date. -- August 1, 2005.

**§85-21-2. Purpose of Rule; Cooperation.**

It is a goal of the workers' compensation program to assist workers to return to work as soon as practicable after a compensable injury and to otherwise provide for high quality, cost effective medical care to injured workers. It is the shared responsibility of the employer, the injured worker, the managed health care plan, private carriers, and the Commission, or upon termination of the Commission, the Insurance Commissioner, to cooperate to achieve this goal.

**§85-21-3. Definitions.**

As used in this exempt legislative rule, the following terms have the stated meanings unless the context of a specific use clearly indicates another meaning is intended.

3.1. "Executive Director" means the executive director of the West Virginia Workers' Compensation Commission pursuant to W. Va. Code §23-1-1b.

3.2. "Commission" means the West Virginia Workers' Compensation Commission as provided for by W. Va. Code §23-1-1.

3.3. "Injury" and derivative words have the meaning ascribed to the term "injury" by W. Va. Code §23-4-1.

3.4. "Injured worker" and "claimant" mean an employee entitled to workers' compensation benefits as the result of a work-related injury, as provided under W. Va. Code §23-4-1.

3.5. "Employer" has the meaning ascribed to that term by W. Va. Code §23-2-1, which includes, but is not limited to, any individual, sole proprietor, firm, partnership, limited partnership, limited liability company, joint venture, association, corporation, company, organization, receiver, estate, trust, guardian, executor, administrator, government entity or any other entity regularly employing another person or persons for the purpose of carrying on any form of industry, service or business in this state.

3.6. "Managed health care plan" means a plan that establishes, operates, or maintains a network of health care providers that have entered into agreements with the plan to provide health care services to injured workers to whom the plan has the ultimate obligation to arrange

for the provision of or payment for services through organizational arrangements for ongoing quality assurance, utilization review programs, or dispute resolution.

3.7. "Provider" means any physician, hospital or other person or organization, which is licensed or otherwise authorized in this state to provide health care services or supplies.

3.8. "Utilization review" means the critical examination of health care services provided to patients especially for the purpose of controlling costs and monitoring the quality of care.

3.9. "Insurance Commissioner" means the insurance commissioner of West Virginia as provided in section one, article two, chapter thirty-three of the West Virginia Code.

3.10. "Insurer" shall mean 1) a self-insured employer; or 2) a private carrier.

3.11. "Private Carrier" means any insurer authorized by the insurance commissioner to provide workers' compensation insurance pursuant to chapters twenty-three and thirty-three of the West Virginia Code, but shall not include self-insured employers.

**§85-21-4. Minimum Plan Standards.**

4.1. Employers, managed health care plans acting on their behalf, private carriers, or third party administrators may submit to the Commission, or upon termination of the Commission, the insurance commissioner, a proposed managed health care plan and if approved, can require its injured workers to use health care providers authorized by the managed health care plan for care and treatment of the injured workers' compensable injuries. The Commission, or upon termination of the Commission, the insurance commissioner, retains sole discretion in approving proposed managed health care plans. All managed health care plans submitted for approval shall include the following features:

a. Co-payments or deductibles shall not be required for medical services rendered in connection with a work-related injury or occupational disease;

b. The injured worker shall be allowed a reasonable choice of providers within the plan;

c. Adequate specialty and subspecialty providers, and general and specialty hospitals must be provided for to afford employees reasonable choice and convenient geographic accessibility to all categories of licensed care. Primary care available within 75 driving miles of the employer's facility is presumed to be geographically reasonable unless the standard of care within the community extends this distance. The availability of secondary and tertiary care shall not be governed by the 75 mile standard;

d. The managed health care system shall provide an informal procedure for the expeditious resolution of disputes concerning rendition of medical services;

e. The employee shall be allowed to obtain a second opinion, at the employer's expense, from a qualified physician within the plan, if available, if a managed health care system physician recommends surgery;

f. The managed health care system shall establish procedures for utilization review of medical services to assure that a course of treatment is medically necessary; diagnostic procedures are not unnecessarily duplicated; the frequency, scope, and duration of treatment is appropriate; pharmaceuticals are not unnecessarily prescribed; and that ongoing and proposed treatment is not experimental, cost ineffective, or harmful to the employee;

g. Mechanisms for utilization review which shall prevent inappropriate, excessive, or medically unnecessary medical services and including:

1. Treatment standards upon which utilization review decisions shall be based (including low back symptoms and injuries to the upper extremities and knees) assuring quality care in accordance with prevailing standards in the medical community of which the plan provider is a member. The standards shall conform to any practice parameters or guidelines for clinical practice adopted by the Commission, or upon termination of the Commission, the

Insurance Commissioner;

2. Mechanisms requiring periodic review to determine that continued treatment of an injured employee is reasonable, appropriate, and medically necessary;

3. Assurance that the managed health care system is conducting utilization review; and

4. Adequate procedures for credentialing providers and evaluating the quality and cost effectiveness of services delivered under the plan.

h. Statements for services shall be audited regularly to assure that charges are not duplicated and do not exceed those authorized by the particular plan;

i. Restrictions on provider selection imposed by a managed health care plan authorized by this chapter shall not apply to emergency medical care;

k. Provisions to allow for the Commission, or upon termination of the Commission, the insurance commissioner, to audit the managed health care plan's operations;

l. Effective methods of informing employees, employers, and medical providers of the services provided by the plan and requirements imposed by the plan, including a twenty-four (24) hour toll free phone number by which information may be obtained concerning plan operations, after-office-hours care, and twenty-four (24) hour access to emergency care;

m. A system to provide authorization to medical providers and health facilities where preauthorization or continued stay review is required by the plan. The authorization shall be recorded in the treatment section of the appropriate billing forms;

n. Case management by either a certified case manager, certified rehabilitation counselor, certified insurance rehabilitation specialist, or a certified rehabilitation registered nurse to coordinate the delivery of health services and return to work policies; promote an appropriate, prompt return to work; and facilitate

communication between the employee, employer, and health care providers. The plan shall describe the circumstances under which injured employees shall be subject to case management and the services to be provided;

o. The managed health care plan must be owned and operated by an organization or entity sufficiently unrelated and independent of the employer in terms of ownership and control so that it can demonstrate independence from said employer; and

p. The managed health care plan shall have a medical director to fulfill the duties set forth in this exempt legislative rule and to perform other duties customarily associated with the medical director of a managed health care plan.

4.2. A managed health care plan may include physical and vocational rehabilitation providers as part of the managed health care plan's network.

4.3. This rule shall not preclude or otherwise limit an injured workers' right to seek care from a provider outside the approved plan or approved opt-out provider at his or her own expense.

#### **§85-21-5. Application Process.**

5.1. The following process shall govern the application process for managed health care plans submitted to the Commission or upon termination of the Commission, the insurance commissioner, for approval pursuant to West Virginia Code Section 23-4-3(b)(2). All managed health care plans must be approved by the Commission or upon termination of the Commission, the insurance commissioner, before utilized. Employers may participate in one (1) or more approved managed health care plans. Applications for initial certification and renewal shall be submitted, in triplicate, in a form acceptable to the Commission or upon termination of the Commission, the insurance commissioner, and shall contain the following information:

a. Plan identification.

1. Plan name and address.

2. Date and state of incorporation.

3. Name, address, and phone number of each corporate officer and director, and of the person who will be the day-to-day plan administrator.

4. Name and address of each owner of more than five (5) percent of the stock or controlling interest in the entity.

5. Name, address, and phone number of the medical director, who shall be a medical doctor (M.D. or D.O. physician) and who shall oversee and monitor compliance with the quality care, utilization review and credentialing provisions of the managed care plan.

6. Name, address, and phone number of the case manager who shall be qualified as either a certified case manager, certified rehabilitation counselor, certified insurance rehabilitation specialist, or certified rehabilitation registered nurse who shall oversee and monitor case management provisions of the managed care plan.

7. Description of the system's organizational structure.

b. Plan qualifications.

1. Description and map of the plan's service area.

2. Name, address, phone number, and specialty of all participating providers. The plan shall provide assurance that all licensing, registration, or certification requirements have been met and are current for the providers to practice in West Virginia (or border states wherein the provider practices) and that each participating provider shall maintain in full force and effect a professional malpractice policy with limits of no less than \$1,000,000 for an occurrence of professional negligence, unless the Commission, or upon termination of the Commission, the insurance commissioner determines, in its sole discretion, that a different malpractice limit is more appropriate given the

providers' specialty or discipline.

3. A specimen of the agreement that each class of medical provider shall execute to participate in the plan.

4. Specimens of the materials which the plan shall provide to workers setting forth the grievance procedure and form, the requirements and restrictions of the plan, and the means of accessing services and treatment within and outside of the service area. The applicant shall detail the time and means by which the materials shall be delivered to employees and employers.

5. Specimens of materials directed at management employees informing supervisors of the necessity of channeling injured workers to the managed health care plan providers and giving immediate notice to the employer, insurance carrier, and plan of the occurrence of an injury.

6. A plan to transition current injured workers to providers within the approved plan; provided that said transfer shall not be mandated any sooner than sixty (60) days from the date approval is received from the commission and , upon termination of the commission, the insurance commissioner.

c. Financial Ability. Each managed health care plan shall demonstrate to the Commission or upon termination of the Commission, the insurance commissioner, that it has sufficient financial resources and professional expertise to perform all of the necessary functions of a managed health care plan. Each managed health care plan requesting certification shall demonstrate such resources and ability to the Commission or upon termination of the Commission, the insurance commissioner, by the following:

1. In the event the applicant has previously provided managed care or other similar medical and administrative services in West Virginia, the applicant shall provide a summary and description of the administrative and medical services provided, together with a list of representative entities for which managed care related administrative or medical services

have been provided; and

2. In the event the applicant has not previously provided services related to the delivery of managed care in West Virginia, it shall be required that, prior to certification, that the applicant post either a performance bond, cash surety deposit, bank letter of credit, or other approved instrument in an amount of \$500,000 with the Commission or upon termination of the Commission, the insurance commissioner, to demonstrate sufficient financial resources to provide all of the administrative and medical services required to be performed under a managed care plan. The bond or cash surety shall be released by the Commission or upon termination of the Commission, the insurance commissioner, sixty (60) days after the managed health care system demonstrates to the Commission or upon termination of the Commission, the insurance commissioner, that all of its arrangements for rendering workers' compensation managed care services in the state have been terminated.

3. If the applicant has an audited financial statement addressing any of its prior operations for the preceding year, a copy of the applicant's most recent audited financial statement shall be submitted to the Commission or upon termination of the Commission, the insurance commissioner.

**§85-21-6. Approval by the Commission.**

6.1. The Commission or upon termination of the Commission, the insurance commissioner, shall notify the applicant in writing of the determination made upon the application for certification or modification thereof, within sixty (60) days of receipt of a complete application. A denial shall be final and unappealable.

6.2. A certificate shall be valid for a period of two (2) years and only for the service area and managed care plan or plans specified by the Commission or upon termination of the Commission, the insurance commissioner. Upon written request made at least sixty (60) days prior to expiration of the current certificate, the Commission may recertify a plan for additional successive two (2) year periods. Geographical areas may be added upon the filing of a

supplemental application demonstrating the managed health care system's ability to serve the expanded area.

6.3. If an application does not meet the requirements for certification or expansion, the Commission or upon termination of the Commission, the insurance commissioner, shall notify the applicant in writing and specify those items deemed deficient. The applicant is granted thirty (30) days from the date of notice by the Commission or upon termination of the Commission, the insurance commissioner, to correct deficiencies through an amended application.

6.4. Certifications of a managed care plan are not transferable. A new application for certification must be filed when fifty (50) percent or more of the ownership or controlling interest of a system has been transferred.

**§85-21-7. Plan Modifications.**

7.1. A managed health care plan, which either implements or experiences material variations as to any matter set forth in the original application or managed care plan, shall obtain approval for the modification by filing a request for modification with the Commission or upon termination of the Commission, the insurance commissioner.

a. Intended variations shall not be implemented until approved by the Commission or upon termination of the Commission, the insurance commissioner.

b. A modification outside the control of the system shall be filed with the Commission within fifteen (15) days of its occurrence.

7.2. Within fifteen (15) days of entering into an agreement with an employer or insurer to provide workers' compensation managed care services, the managed health care plan shall submit notification thereof to the Commission or upon termination of the Commission, the insurance commissioner. The notification shall identify the employer or employers with whom the managed health care plan has contracted and the certified managed care plan applicable to that employer. Notification shall be deemed

approved unless disapproved by the Commission or upon termination of the Commission, the insurance commissioner, in writing within thirty (30) days of filing. The plan shall promptly furnish any information deemed necessary by the Commission or upon termination of the Commission, the insurance commissioner, to review the notice. When an employer or insurer terminates a contract with a managed health care plan, the managed health care plan shall file notification with the Commission or upon termination of the Commission, the insurance commissioner, within fifteen (15) days of the occurrence, indicating the employers for whom managed care services have been terminated and the effective date of the termination.

**§85-21-8. Suspension or Revocation of Certification.**

8.1. The certification of a managed care plan by the Commission or upon termination of the Commission, the insurance commissioner, may be suspended or revoked if:

a. Service is not being provided according to the terms of the certified managed care plan, or in accordance with prevailing treatment standards, or in accordance with treatment standards or practice parameters adopted by the Commission, or upon termination of the Commission, the insurance commissioner;

b. The plan for providing services or the contract with the insurer or health care provider fails to meet the requirements of the West Virginia Code or applicable state rules and regulations;

c. Any material false or misleading information is intentionally submitted by the managed health care system or participating provider to the Commission or upon termination of the Commission, the insurance commissioner, the employer, or the insurer;

d. The managed health care system knowingly or negligently utilizes a health care provider whose license, registration, or certification has been suspended or revoked, or who is otherwise ineligible to provide treatment

of the type rendered to an injured employee; or

e. For any other good faith basis as determined in the sole discretion of the Commission or upon termination of the Commission, the insurance commissioner.

8.2. The Commission or upon termination of the Commission, the insurance commissioner, may investigate the operations of a certified managed health care plan at any time and the plan and its providers shall cooperate in any investigation by the Commission or upon termination of the Commission, the insurance commissioner. Should the Commission or upon termination of the Commission, the insurance commissioner, find that reasonable grounds for termination or suspension of a managed care plan certification exist, written notice setting forth those grounds shall be mailed to the system by certified mail, return receipt requested. The system is granted fifteen (15) days from the date of the verified receipt or refusal of the notice in which to file written response. Thereafter, the Commission or upon termination of the Commission, the insurance commissioner, shall render a written decision by which the certification of the plan may be terminated, suspended, or conditionally continued to permit the correction of deficiencies directed. The Commission's or upon termination of the Commission, the insurance commissioner's, decision is final and unappealable.

**§85-21-9. Other Administrative Provisions.**

9.1. An employee who reports an injury alleged to be work-related or files an application for adjustment of a claim shall execute a waiver and consent of any privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation. Notwithstanding any other provision of the West Virginia Code, any physician, psychiatrist, chiropractor, podiatrist, hospital, or health care provider shall, within a reasonable time after written request by the employee, employer, or Commission or upon termination of the Commission, the insurance commissioner, provide the requesting party with any information or written material reasonably related to any injury or disease for which the employee claims compensation.

9.2. When a provider of medical services or treatment makes referrals for medical services or treatment to a provider or entity in which the provider making the referral has an investment interest, the referring provider shall disclose that investment interest to the employee, the Commission or upon termination of the Commission, the insurance commissioner, and the employer or the third party administrator responsible for paying for the medical services or treatment, within thirty (30) days from the date the referral was made.

9.4. Employers may contract with multiple managed health care plans in order to maximize access for their employees.

9.5. Temporary total disability must be certified by a provider within the approved managed health care plan, unless the opt-out provisions of this rule have been satisfied.

**§85-21-10. Minimum Grievance Standards.**

10.1. Each workers' compensation managed care plan shall contain an expeditious, informal grievance procedure to resolve disputes by employees and providers relative to the rendition of medical services. A detailed description of the employee grievance procedure shall be included in informational materials provided to employees and a detailed description of the provider grievance procedure shall be included in all provider contracts.

10.2. The grievance procedure shall meet the following minimum requirements:

a. Notice. A grievance is made when a written complaint or written request is delivered by the employee or provider to the managed health care system setting forth the nature of the complaint and remedial action requested.

b. Time frame to file grievance. The employee or provider shall file a grievance within thirty (30) days of the occurrence of the event giving rise to the dispute.

c. Resolution. The managed health care system shall render a written decision upon a grievance within thirty (30) days of receipt by

the managed health care system of the grievance.

d. Arbitration. Managed care plans may provide for alternate means of dispute resolution including arbitration and mediation. In that event final resolution of a grievance shall not be subject to the time constraints set forth in paragraph c of this subsection. In all cases, resolution mechanisms shall be expeditious and where treatment matters are at issue reflect the need for prompt resolution.

10.3. Record of grievance proceedings. The managed health care plan shall maintain records for two (2) years of each formal grievance to include the following:

a. A description of the grievance; the employee's name and address; names and addresses of the health care providers relevant to the grievance; and the managed health care system's and employer's name and address; and

b. A description of the managed health care system's findings, conclusions, and disposition of the grievance.

10.4. Appeal. The managed health care plan shall notify the applicable self-insured employer, private carrier or the Commission of its final decision so that either the self-insured employer, private carrier or the Commission can issue a protestable order setting forth the decision. The Commission's or upon termination of the Commission, the insurance commissioner's, role is administrative only and it will not rule on the merits of the dispute. The time period set forth in the West Virginia Code to protest to the Office of Judges shall begin to run upon issuance of the protestable order and shall be tolled until that time.

**§85-21-11. Reporting Requirements.**

11.1. Each certified managed health care plan shall submit a report to the Commission or upon termination of the Commission, the insurance commissioner, semi-annually containing the following information:

a. Number of employees treated by the managed care plan;

b. Number of work-related injuries or diseases by ICD-9 code treated under the managed care plan in the preceding year;

c. Breakdown by ICD-9 codes of injuries and diseases treated;

d. Total medical costs;

e. Average medical cost per injured employee by type of injury;

f. Average medical cost per diseased employee by type of disease;

g. Breakdown of medical cost elements as to type of physician utilized, hospital costs, drug costs, and other costs;

h. Number of grievances filed, and summary of action taken; and

i. Number of days by type of injury and disease for which an employee has been released from work.

**§85-21-12. Provider Verification.**

12.1. Each employer which provides medical services through a managed care plan will provide to the injured employee a written certification of workers' compensation managed care coverage as soon as practicable following notice of a compensable injury or disease requiring medical services. The verification shall contain the following information:

a. Employer name, address, and phone number;

b. Name and telephone number of the managed health care system to be contacted; and

c. Employee name and Social Security number.

12.2. Possession of such verification is not to be construed as authorization for medical service or payment.

**§85-21-13. Injured Worker Opt-Out Standards.**

13.1. Injured workers may access providers who are not participating plan providers:

a. For emergency care when access to a health care provider within the managed health care plan is unobtainable for the acute phase of care;

b. When authorized treatment is unavailable through the managed care plan; or

c. To obtain a second opinion when a managed health care plan physician recommends surgery and another qualified physician within the plan is not available for consultation.

13.2. Injured workers may access providers who are not participating plan providers for treatment purposes only if the injured worker has established by competent evidence all of the following:

a. The injured worker has been treated by providers solely within the employer's managed care plan for a period of at least one (1) year;

b. That for reasons related to the treatment alone, the injured worker has not made progress toward recovery that is reasonably consistent with the Commission's or upon termination of the Commission, the insurance commissioner, treatment guidelines;

c. That the injured worker establishes to a reasonable certainty that proposed treatment outside the employer's managed care plan would more likely provide the injured worker with a better clinical outcome than the current treatment or rehabilitation plan; and

d. A condition of the right to opt out under this provision shall be that the services secured outside the plan are for treatment purposes only and the provider shall not be permitted to rate the injured worker for permanent partial or permanent total disability. Any provider providing services pursuant to this provision shall be barred from providing such a rating.

**§85-21-14. Severability.**



If any provision of these rules or the application thereof to any entity or circumstance is held invalid, the invalidity will not effect the provisions or the applications of these rules which can be given affect without the invalid provisions or application and to this end the provisions of these rules are declared to be severable.