PROVIDER GRIEVANCES

DISPUTE RESOLUTION & GRIEVANCE PROCEDURES
Initial requests for reimbursement disputes received from a provider, are not considered grievances, even if they are on the grievance form (AHCA Form No. 3160-0019).

If a request comes in on the grievance form – it is a grievance unless it is the initial request for reimbursement dispute – see above. (ACHA form #3160-0019 available in English and Spanish)

Any subsequent requests for reimbursement dispute received from a provider are not considered grievances unless they are submitted on grievance form (AHCA Form No. 3160-0019).

These requests are handled within 44 days of receipt either by telephone communication with the provider or by issuance of an EOMB.

Who may file a grievance?

The provider may file a grievance. The provider receives a Heritage Summit HealthCare LLC Provider Manual that includes a grievance form and grievance instructions. This Provider Manual is sent once the provider is credentialed and again at re-credentialing.

Written grievance procedures:

Requests for reimbursement disputes received from a provider, on AHCA Form No. 3160-0019 are considered a written grievance.

Provider must submit grievance within 30 days after receipt of EOMB. A grievance must be resolved in 44 days from receipt of grievance.

The billing specialist has 14 days to review the provider dispute and determine if additional reimbursement is warranted. At this time, a Letter of Determination will be sent to the provider. If the request for reimbursement dispute is disallowed, it will then be forwarded to the Formal Grievance committee for review.

The Formal Grievance Committee consists of five voting members.

Dr. Joel Grossman, of South Florida Utilization Review (SFUR), is the only permanent member. The other four members rotate on a weekly basis. They include a claims manager, a claims supervisor, a nursing supervisor and a case manager.

The Formal Grievance committee has 30 days to review the provider grievance and make its determination, unless the provider and the FGC mutually agree to an extension that is documented in writing. The only way an issue should go to the FGC is if it has already been denied.

The Formal Grievance Committee has 30 days to advise if it will provide or disallow the reimbursement dispute. Once a grievance goes to the formal committee, the decision of the committee is final.
QUALITY ASSURANCE PROGRAM

GOALS, OBJECTIVES AND METHODOLOGY
The quality assurance program is designed to assure appropriate care and treatment for injured workers through the monitoring of health care services provided, utilizing prevailing standards of medical practice. The program focuses on maintaining adequate network access, claimant satisfaction, successful outcomes, and cost effectiveness. A successful return to work through open communication with the employer, employee, provider and carrier is expected.

The quality assurance program is the continuous monitoring of the MCA’s activities to promote these goals and objectives. The methodology for this ongoing process is described in the procedures outlined throughout this filing. This methodology also incorporates the use of a committee whose purpose is to evaluate various aspects of the program on an ongoing basis in an effort to promote continuous improvement.

PROVIDER REMEDIAL ACTION
If at any time during the quality assurance or utilization review process a provider concern is identified, based on the nature of the concern, we will attempt to resolve it through informal interventions, such as, peer to peer discussions or written communications from the case manager or medical services coordinator. In the event that the concern is serious in nature or a trend is identified, the information will be forwarded to the network manager, medical director and/or the Credentialing Review committee for further educational/corrective action or possibly termination.

PROVIDER REVIEW
A system, which allows for the ongoing review (no less than annually) of provider practices, including both clinical and billing practices, is in place. This system includes extensive medical records review. Through the records review, case managers are able to verify services rendered, monitor progress, and identify patterns, which may warrant review. This system also includes extensive bill audit and review. The close review of provider bills remains one of the most effective ways to identify potential patterns of abuse. Additionally, the information system maintained by the MCA contains key data elements related to all medical activity on a case. These elements include information about authorizations, diagnoses, referrals, hospitalizations, and billed procedures. The availability of this information again allows for review of providers through reporting mechanisms determined by the Quality Improvement Committee.

MEDICAL RECORDS REVIEW
Medical records received will be reviewed in a manner sufficient and/or dictated by state statute, rules, regulations or guidelines to determine that the health care practitioners are providing timely and accurate information necessary for the medical management of the claim. The records will be evaluated for legibility and completeness, including but not limited to a complete history and physical. The history and physical will include subjective and objective findings, past medical and surgical history, social history, diagnosis(es), assessment and treatment plan.

Timely receipt of medical information is critical to the management of the claim. For this reason,
the medical services coordinators will routinely obtain updated status information from the providers via telephone. The purpose of the medical records review will be to verify that the written documentation supporting the telephone information is received on a timely basis.

CONFIDENTIALITY
The MCA has an obligation to maintain confidentiality relevant to medical records within its possession. The records are maintained in a secured environment. Any medical information provided to another party related to the workers’ compensation claim is screened by the medical services coordinator for appropriateness of the information. Requests for medical information by parties outside of the workers’ compensation claim will not be honored without the express written consent of the claimant. Should the MCA require medical records not specifically related to the workers’ compensation claim but necessary for the management of the claim, a signed medical release will be obtained and used to maintain the providers’ obligation for confidentiality.

HIPAA DISCLOSURES FOR WORKERS’ COMPENSATION PURPOSES

[45 CFR 164.512(l)]
“The HIPAA Privacy Rule does not apply to entities that are workers’ compensation insurers, workers’ compensation administrative agencies, or employers, except to the extent they may otherwise be covered entities. However, these entities need access to the health information of individuals who are injured on the job or who have a work-related illness to process or adjudicate claims, or to coordinate care under workers’ compensation systems. Generally, this health information is obtained from health care providers who treat these individuals and who may be covered by the Privacy Rule. The Privacy Rule recognizes the legitimate need of insurers and other entities involved in the workers’ compensation systems to have access to individuals’ health information as authorized by State or other law.

The Privacy Rule permits covered entities to disclose protected health information to workers’ compensation insurers, State administrators, employers, and other persons or entities involved in workers’ compensation systems, without the individual’s authorization.”

Please follow this link for more specific information:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/workerscomp.html

FINANCIAL ARRANGEMENTS
The MCA utilizes a combination of discounted fee for service and global case rates to reimburse its providers. Providers being reimbursed on a fee for service basis receive fair reimbursement for providing quality services to employees while being closely monitored for instances of both under- and over-utilization. Global case rates provide incentives for better managed treatment and focus on outcomes in those areas most prone to misutilization. As a provider in the HSHC PPO network you agree not to require prepayment of any services. As a provider in the HSHC PPO network you agree to adhere to Florida Statute 440.105 (7) “an injured employee or any other party making a claim under this chapter shall provide his or her personal signature attesting that he or she has reviewed, understands and acknowledges the following statement: “Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured
program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234.” If the injured employee or other party refused to sign the document attesting that he or she has reviewed, understands, and acknowledges the statement, benefits or payments under this chapter shall be suspended until such signature is obtained.”

HOSPITAL PRE-CERTIFICATION AND CONCURRENT REVIEW

- Request is received for authorization of surgery or hospitalization.
- We instruct the requestor that pre-certification from the case manager is required. In some instances medical services coordinators (adjustors) can authorize certain types of surgical procedures and diagnostic tests.
- The file is referred to the case manager for review of medical records.
- The case manager initiates contact with the physician to confirm details of the authorization request, and obtain any additional documentation needed.
- The case manager may require a second opinion based upon established criteria and associated clinical findings in conjunction with our managed care plan of operation.
- If the case manager has any questions regarding medical necessity of the surgery or hospitalization, the file is immediately referred to the medical care coordinator (medical director).
- The MCC’s determination will be communicated back to the case manager, who will notify the requesting parties.
- If the surgery/hospitalization is appropriate, the case manager will document length of stay as dictated by the physician or as required by the State’s applicable and prevailing UR rules.
- The provider will be notified of the results of the pre-certification process.
- In the event of a non-certification, the provider will be notified of the basis for the determination and advised of their ability to utilize the grievance process.
- The results of the pre-certification are documented in both the claim file and the system.
- The case manager will monitor the hospitalization for timely discharge or extended certification, if necessary.

PRE-AUTHORIZATION

All requests from the treating physician to perform services, as well as any request for referral, must be authorized by the medical services coordinator or case manager. These authorizations will be based on medical necessity and the use of guidelines referenced in this filing. All authorizations are maintained in our computer system. Reimbursements will not be made for services which were not previously authorized. Through the use of a pre-authorization process, which is required for reimbursement, the MCA is able to monitor and prevent inappropriate and excessive treatment. For workers’ compensation patients, call 1-800-282-7644. Please have the patient’s name, Social Security number and/or the case manager’s name available. For group health patients, please
COST CONTAINMENT AND UTILIZATION REVIEW
In addition to the pre-certification and pre-authorization process, an extensive review is performed at the time of bill adjudication. All bills are adjudicated by experienced staff members utilizing a sophisticated program which applies appropriate contracts, Florida workers’ compensation reimbursement rules and regulations, maximum reimbursement allowances, correct coding guidelines and prevents duplicate reimbursements. This comprehensive adjudication process is supplemented by additional screening and review processes.

SCREENING MEDICAL BILLS
Proper billing is critical to ensure correct reimbursement and the maintenance of data which affects the establishment of MRA’s and the identification of exceptional practice patterns for possible utilization review. Bill forms must be completed legibly and in compliance with the applicable rules and have attached all required AHCA forms and health care reports. Medical bills are screened for proper forms completion. If the bill is submitted on an incorrect form, it is returned to the provider with a form letter. Bills that are incomplete or incorrect are processed with an EOBR identifying the errors and returned to the provider.

DETERMINING UNSCHEDULED REIMBURSEMENTS
Reimbursement for By-report (BR), ANE and unlisted procedures is based upon the MCA’s review of the submitted documentation and the prevailing charges for specific services based on data which is representative of Florida charges or per peer review determination. All bills coming to Cost Containment for payment which contain BR, ANE or unlisted procedures are referred to a reviewer. Based on this analysis, the bills are either sent for peer review to determine the appropriate payment, or the reasonable and customary amount for the geographical area of the provider is paid using a RBRVS/UCR Database. The rationale for determining the allowance is documented.

CONCURRENT FOCUSED REVIEW
Concurrent utilization review is performed on cases with selected criteria that are indicative of possible misutilization and improper billing practices. Prior to reimbursement, the appropriate staff for determination of medical necessity and appropriate allowances reviews designated billings.

The following criteria are used to designate bills for focused review:

- All inpatient and outpatient hospital bills.
- Assistant Surgeon.
- Co-Surgeon.
- Ambulatory Surgery Centers.
- Anesthesia bills with P3 – P5 modifiers and/or emergency anesthesia.
- All bills with a 22 modifier.
- All bills with ANE and BR.
- All unlisted procedure codes.
The bills are reviewed for overutilization, misutilization and improper billing practices. Recommendations are then made as to reimbursement and final disposition. If necessary, referral may be made for peer review.

**RETROSPECTIVE FOCUSED REVIEW**
Utilization review will be performed on cases or files selected by defined criteria that is indicative of possible misutilization or improper billing practices. Retrospective Focused Reviews will include claims with multiple prescribing physicians. Claims with multiple providers will be defined as those having more than one orthopaedist, neurologist, chiropractor, osteopath, psychiatrist, psychologist, podiatrist, physical therapist, occupational therapist, internist, endocrinologist or surgeon, treating. These claims will be identified by the medical services coordinator or case manager and referred to the medical care coordinator for review.

**TYPES OF POTENTIAL ABUSE**
Isolated incidents of the following health care and billing practices usually do not constitute abuse, but may be indicators of patterns or trends that could be developing or have already developed.

- **Double Billing**: The submission of bills for health care services in such a manner as to receive duplicative payments for a service.

- **Common Referrals**: The referral of patients by two or more health care providers among themselves for services, tests, consultations, or treatments that are not medically necessary.

- **Cross Billing**: The submission of bills for health care services to different payors in such a manner as to receive payments which would otherwise be disallowed or reduced.

- **Claimant Billing**: The practice of requesting the claimant to pay for services which were for a workers’ compensation related claim, but were disallowed, paid at a reduced amount or denied based on lack of medical necessity.

- **Fragmented Billing**: Bills for concurrently provided services that are submitted on separate forms and at different times resulting in the payment for service(s) which would otherwise be disallowed due to limitations, exclusions and global fee restrictions.

- **Missing Modifiers**: Bills for services, such as the professional component, in which the modifier is not included and the resulting payments are for services at a level greater than provided.

- **Non-Disclosures**: Health care providers referring a claimant to another provider in which the referring provider has a financial interest and does not disclose the same to the employer and employee in writing.

- **Over-charging**: The billing for services to a workers’ compensation reimbursement source at rates which exceed what the provider usually charges private paying patients and other payors.
Over-itemization: The submission of claims with the various integral steps of a procedure billed as separate codes. Also known as split fee billing.

Over-prescribing: A physician ordering tests, consultations and treatments in excess of what is medically required.

Overutilization: The performance or ordering of medically unnecessary services.

Prolonged Follow-up: A provider requiring or recommending the patient return for follow-up care, treatments or evaluations in the absence of medical necessity.

Self-referrals: Providers referring patients to another provider in which there is a financial interest and the services are medically unnecessary or overpriced.

Services Not Rendered: Billing for services that were not rendered or not rendered at the level or urgency they were billed.

Substandard Care: The provision of medical or health care services which do not meet acceptable medical or professional standards.

Upcoding: The billing for services at a level of service that is greater than the level provided.

If abuse is suspected based on one of the above indicators, the case will be referred for peer review. If warranted, multiple cases may be referred for review. When appropriate, the results of the review may be forwarded to the network manager and/or the QI committee for further discussion.

The process for resolution of provider reimbursement or utilization disputes is described in the Grievance Procedures.

MEDICAL CARE COORDINATION

The WCMCA aggressively pursues the goal of quality care resulting in return to work for injured employees through early intervention. Medical care coordination is available immediately following the injury through reporting by telephone. Early coordination includes immediate contact with the employer to discuss possible return to work options when the potential for lost time exists. Through the efforts of the medical services coordinator, case manager and medical care coordinator (medical director), proactive case management continues through the life of the claim.

Effective July 2, 2004, the Division of Workers’ Compensation adopted the DWC – 25 Medical Treatment/Status Reporting Form. (Form enclosed) Please note when completing this form to pay special attention to Section IV of the DWC – 25. Section IV addresses the determination of functional limitations, restrictions and the ability to return to work. By providing this information you will assist in returning the employee (if able) to light/modified duty or full work capacity. Our clients have a strong commitment to seeing that injured workers return to work, as often as possible. Please take a moment and read the enclosed Back2Work flyer from Summit. This information for
physicians in the HSHC network shares Summit’s commitment to working with the providers, employers and injured workers to get back to work.

The Division has developed a Word template for the DFS-F5-DWC-25 Florida Workers’ Compensation Uniform Medical Treatment/Status Report Form for use by health care providers. The Word template will allow health care providers to save the forms as both Word documents and Word templates in their medical records electronic systems which will permit them to design their own methodologies to merge demographic data with the Word format. This format is in addition to the PDF and Excel formats already available on the Division’s website. The Word format may be found under the website sections entitled, "News" and "Rules & Forms", under the Tab marked 69L-7 or at http://www.myfloridacfo.com/WC/forms.html.

Questions or difficulties encountered when using the form should be directed to the Workers’ Compensation Medical Services Unit via Workers.MedService@fldfs.com.


All catastrophic cases are referred to a specialized unit for handling. If outside medical care coordination is needed, the assistance of a qualified rehabilitation provider may be requested.

An important component of this medical care coordination is assisting the injured employee in the selection of a primary care physician as well as one change in provider during the course of treatment for a work-related injury.

Summit’s workers’ compensation managed care arrangement (WCMCA) may request a second opinion for any surgical procedure(s) or hospital admissions.

Injured employees may ask for one change of physician/facility during the course of treatment for a work-related injury by calling the Summit’s workers’ compensation WCMCA at 1-800-282-7644.

The Summit workers’ compensation MCA medical services coordinator or case manager will assist in selecting a second physician within the network.

**PRACTICE GUIDELINES**

The WCMCA will incorporate the use of Agency approved practice parameters in both a prospective and retrospective manner. The guides will be used to assist medical services coordinators and case managers in giving appropriate authorizations for services requested by the treating physician. Additionally, the medical director will utilize the guides or other peer-physicians involved in reviewing cases. The medical care coordinator (medical director) will consider these guides when approving referrals and treatment plans.

The MCA has also adopted the ODG (Official Disability Guidelines) and InterQual Guidelines as its criteria for evaluating appropriateness of care. These guidelines will be used to assist in giving
appropriate authorizations and facilitating timely return to work. Additionally, these guides will serve as a tool for assessing outcomes of care.

**EMPLOYEE SATISFACTION**
It is important to note that this MCA plan is designed to promote and monitor quality of care. We recognize that in addition to the MCA’s satisfaction with the quality of care being rendered, it is also important that the injured employees perceive that they have received quality care. Given the nature of a workers’ compensation injury, and the negative connotation that is so often associated with it, our goal is to create a positive experience for the injured employee whenever possible. While specific complaints will be evident through the grievance process, the MCA will attempt to also measure overall satisfaction with the program. *Grievances will be reviewed at least annually to identify any trends or patterns that should be reported to the Quality Improvement Committee.*

**RECEIPT OF MEDICAL RECORDS AND WORK STATUS**
Given the objective of timely and appropriate return to work, receiving information regarding the injured employee’s work status, capabilities, and limitations, is imperative. To expedite this process, the medical services coordinators may routinely obtain this information via telephone. Again, the purpose of the medical records review is to ensure that the supporting documentation regarding work status and restrictions is received in a timely manner. Please use the form required by the State of Florida, DWC-25, which emphasizes what the employee is capable of as well as any restrictions which may apply, information regarding maximum medical improvement and any associated permanent impairment rating is critical. This information is also addressed on the status form. The medical services coordinator may routinely seek this information via telephone with supporting documentation (DWC-25) from the physician to follow.

It is important to note that this Managed Care Arrangement is fully integrated with the insurer’s servicing organization. All documentation on a claim is maintained in a common file. Therefore, receipt of medical documentation by the insurer is concurrent with receipt of that information by the Managed Care Arrangement.

**TRAINING AND EDUCATION PROCEDURES**
The health care providers and administrative staff of the Managed Care Arrangement should receive training and education on the provisions of Chapter 440 and administrative rules that govern the provision of remedial treatment, care and attendance of injured workers.

According to FS 440.13(3) (a), the Agency governing the physicians’ field of practice will review providers for certification that covers the subject areas of cost containment, utilization control, ergonomics and the practice parameters adopted. During the credentialing process verification will be completed. If there are any questions, please call 1-800-282-7644, and ask to speak with a Heritage Summit HealthCare LLC (HSHC) representative.

Providers will receive ongoing training on the Managed Care Arrangement as a need is identified through “Provider Concerns.” HSHC network representatives, medical services coordinators, case
managers and management staff can also provide training and assistance by telephone. In addition, providers may request additional training for their staff as needed by calling 800-282-7644 and requesting to speak with an HSHC network representative.

**PROVIDER SITE VISIT**
At its sole discretion, HSHC may include on-site evaluation of the provider’s facility and procedures as part of the credentialing process. On-site visits may also be done randomly or when a need is identified by telephone or identified through the provider concern form.

**UPDATES**
Periodically the network will seek information about licensure activity or sanctions with respect to any participating providers.

Participating physicians, providers, and any other health care professionals will be subject to the credentialing plan and procedures set forth every three years.

Participating providers may be sent a questionnaire requesting updated information similar to the original application. We request that this questionnaire be returned fully completed within 120 days, if this is not returned within 120 days the provider may be considered for termination. The Network Representative will review each on a case-by-case basis. The network may choose to obtain information from the following, but is not limited to sources such as directly receiving certificates of coverage from the provider’s insurance carrier(s) and external verification of information requested from the participating provider.

Re-credentialing will include an evaluation of the completed questionnaire and other information, including, but not limited to:
- Provider Questionnaire:
- Valid State Professional license;
- Valid DEA certification;
- Valid medical malpractice/liability coverage, acceptable to HSHC standards;
- Current malpractice claims history;
- Current statement regarding provider’s physical/mental health status and their lack impairment due to chemical dependency/substance abuse, signed by the provider;
- Clinical privileges in good standing at the hospital designated by the provider as the primary admitting facility;

The process may include addressing the following concerns:
- Complaints from members
- Quality assessment issues
- Utilization management issues
- Member satisfaction surveys
Contract will terminate **upon notification** of the effective date of retirement or cessation of medical practice or health care services.

**DISCIPLINE AND TERMINATION PROCEDURES**
The following procedures are to serve only as a guide. The network in its sole discretion may follow the procedures set forth or use alternative procedures deemed appropriate. Any time the network receives information suggesting a review, investigation, or disciplinary action be taken; it will begin to compile this information. If the network at sole discretion, decides information is needed from the provider or other sources, then a request may be made to have the provider discuss relevant issues to the investigation. The network has complete discretion in recommending discipline or making other recommendations, regardless of whether those factors were mentioned in its credentialing plan.

If at any time during the quality assurance or utilization review process a provider concern is identified, based on the nature of the concern, we will attempt to resolve it through informal interventions, such as, peer to peer discussions or written communications from the case manager or medical services coordinator. In the event that the concern is serious in nature or a trend is identified, the information will be forwarded to the network director for further educational/corrective action and subsequently to the QI and/or Credentialing Review committees for their review if necessary.

Regardless of any provisions in its credentialing plan, the network, at its sole discretion, may terminate the participation of any provider according to the terms in that provider’s written agreement (or for failure as set forth within the requirements of its credentialing plan or for any other reason, at its sole discretion.)

The provider will be given written notice if the network recommends there be disciplinary action or termination of that provider’s participation status. Written communication to the provider will include the following:

- The effective date of the disciplinary or termination action;
- A short summary of the basis for the recommendation.
- An outline of the appeals process

If the network director or medical director determines, in his or her sole discretion, that the health of any member is in danger due to a provider’s actions or lack thereof, the network director or the medical director may immediately suspend or restrict the participation status during which time the provider will be investigated by the network to determine whether further disciplinary action is warranted.

The network at its sole discretion, may recommend disciplinary action be taken when a provider has failed to comply with the requirements set forth or for any other reason.

Considered in making recommendations is such information as quality of care, financial, or any other factors deemed relevant. Disciplinary actions which may be taken include but are not limited
to the examples below:

- Termination of the provider’s participation.
- Temporary suspension of the provider’s participation status.
- Limiting referrals.
- Requiring the provider to obtain additional verification or training in specific types of care.
- Monitoring the provider to determine if substandard or non-compliant behavior continues.

The network at its sole discretion, may recommend termination of a provider. This may be initiated by any information the network deems appropriate, which includes but is not limited to the following examples:

- Provider behaves in a non-professional manner which includes uncooperative, unprofessional, or abusive behavior toward any member of the credentialing entity’s staff;
- Provider fails to comply with the utilization review, quality assurance, or any other policy the Credentialing Committee, in its sole discretion, has deemed appropriate;
- Provider abuses the billing practices which would include, but not be limited to, fraudulent billing, submitting billing with false, incorrect, or duplicate information to obtain payment, double billing, manipulation of CPT codes, or fragmented charges;
- Provider renders care which, at the sole discretion of the network, has harmful or potentially harmful effects, or is unacceptable as set forth or as determined;
- One or more of the requirements as set forth in this plan has not been met.