

Department of Labor
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Readopt Lab 701.01 through 702.03, effective 8/1/08 (Document # 9217), cited and to read as follows:

CHAPTER Lab 700 MANAGED CARE PROGRAMS IN WORKERS' COMPENSATION

Statutory Authority: **RSA 281-A: 23-a, V and VI (b), RSA 281-A:60, I (a) and (p)**

PART Lab 701 PURPOSE AND APPLICABILITY

Lab 701.01 Purpose. This chapter sets forth the rules which govern the implementation of RSA 281-A:23-a pertaining to the approval and use of managed care programs in workers' compensation.

Lab 701.02 Applicability. These rules shall apply to all managed care programs upon adoption.

PART Lab 702 DEFINITIONS

Lab 702.01 "Healthcare provider" means a hospital, physician or medical specialist offering services within the managed care system.

Lab 702.02 "Hospital service area" means a regional geographic grouping of cities and towns that have been identified by the health services planning and review board in accordance with He-Hea 1000 as a means of breaking the state into units of analysis.

Lab 702.03 "Independent medical examination" means a medical examination conducted by a qualified healthcare provider at the request of either the injured employee or insurance carrier solely for the purpose of determining compensability, degree of disability or degree of impairment arising from the injury.

Readopt with amendment Lab 702.04, effective 12/1/11 (Document # 10038), to read as follows:

Lab 702.04 "Injury management facilitator" means an individual employed by, or contracted as a worker for payment by, a managed care organization, and approved by the department of labor and workers' compensation advisory council using criteria specified in Lab 703.01(am) to provide case management services to injured workers receiving services within a workers' compensation managed care system.

Readopt Lab 702.05 through Lab 702.09, effective 8/1/08 (Document # 9217), to read as follows:

Lab 702.05 "Managed care organization" means an organization which coordinates medical services for workers' compensation cases in accordance with RSA 281-A:23-a.

Lab 702.06 "Network" means a system of healthcare providers, contracted by a managed care organization, to render services, as needed, to workers' compensation injured employees unless a different definition is specified.

Lab 702.07 “Protocol” means the medical guidelines established by a managed care organization to which a healthcare provider, wishing to provide services within a managed care program, agrees to comply.

Lab 702.08 “Second opinion” means a medical examination conducted by a qualified healthcare provider at the request of an injured employee within a managed care network solely for the purpose of determining or confirming a diagnosis or the proper course or treatment for the injuries.

Lab 702.09 “Workers' compensation advisory council” means the council established in accordance with RSA 281-A:62.

Readopt with amendment Lab 703.01, effective 8/1/08 (ss by Document # 9217) as amended effective 12/1/11(Document # 10038), cited and to read as follows:

PART Lab 703 MANAGED CARE PROGRAM CRITERIA AND APPROVAL PROCESS

Lab 703.01 Necessary Components.

(a) No managed care program in workers' compensation shall be offered or used in this state unless the commissioner finds that the program meets the requirements of (b)-(p) below.

(b) The network of health care providers shall be sufficiently comprehensive with respect to both geography and medical specialties.

(c) A network shall be deemed comprehensive if it includes 2 or more vocational rehabilitation providers, for injuries covered by the program.

(d) A network of health care providers shall be sufficiently comprehensive with respect to geography and medical specializations when the commissioner finds that it offers a covered employee in each hospital service area or county a choice of 2 or more of each of the following health care providers:

- ~~(1) Acute care hospitals;~~
- (21) Chiropractic services;
- ~~(32) Family practice~~ **Occupational medicine physicians** or internal medicine physicians;
- (43) Neurologists;
- (54) Neurosurgeons;
- ~~(65) Ophthalmologists;~~
- ~~(7) Occupational medicine physicians;~~
- (86) Occupational therapists or Physical therapists;**
- ~~(97) Orthopedic physicians and surgeons;~~
- ~~(108) Psychiatrist or rehabilitation medicine physicians;~~
- ~~(11) Podiatrists;~~
- ~~(12) Physical therapists;~~

~~(13) General surgeons;~~

~~(14) Hand surgeons; and~~

~~(15) Spine surgeons.~~

(e) In cases where 2 or more of such choices are not available in each hospital service area or county covered by the proposed network, the program shall be considered comprehensive if it allows access to **such** medical services. ~~as are reasonably available to the general public in such locality in an adjacent hospital service area or county.~~

(f) The program may include additional healthcare providers and medical services other than those listed in part (d) above, ~~but an injured employee shall use as part of the network only those health care providers listed in part (d) above. In addition, an injured employee shall use the services of other medical physicians and nurse practitioners that are part of the approved managed care program,~~ provided the injured employee has a choice of at least 2 such providers within the radius of 25 miles from the injured employee's residence. **An injured employee shall be required to use as part of the network only those health care providers.**

(g) The program shall provide for treatment and remedial services, nursing, medicines and mechanical and surgical aids outside of the network under the following circumstances:

(1) If the necessary services or aids are not available to the employee within the network, or if emergency circumstances prohibit use of the network;

(2) ~~If~~ **When transferring of care** outside the network is recommended **by an in-network provider**, the reasonableness of future treatment shall be determined by reviewing the physician's recommendations and the network's availability to assist the employee in obtaining the needed services and aids within the network;

(3) If emergency circumstances in which treatment or aids required to protect the health of an injured employee are required to be applied or administered immediately and without opportunity to notify the person or persons designated for such notification by the program or to follow the directive of such person or persons if such notification occurred;

(4) If an injured employee has been treated by a provider who is not a member of the network to treat a recurrence or aggravation of an injury treated by such provider within the prior 6 months, as long as such provider complies with all the terms, conditions, protocols, referral procedures, and levels of reimbursement established by the network; or

(5) If unique circumstances based upon an individual case are sent in writing to the commissioner showing that the requested services or aids were not available within the network the commissioner shall investigate the circumstances and the network's resources to determine if it is necessary to seek out of network services and shall advise the parties of the decision.

(h) The program shall include a process for determining professional qualifications of health care providers in the network. Internal credentialing procedures shall be sufficient, as long as the data utilized in the process of credentialing shall be in enough detail to enable the commissioner to verify the validity of the process.

(i) The program shall provide for acceptable quality assurance measures. Acceptable quality assurance measures means regularly utilized procedures to assure that medical providers shall be continually qualified by training and experience to administer the treatment or aids offered to covered employees. Additionally, following such treatment and aids, medical records shall be retained and available for inspection. These measures shall include the use of a quality assurance committee which regularly inspects such evidence or records and the quality of care being delivered by the program.

(j) The program shall include both in-patient and out-patient case management, medical, vocational and rehabilitation case management that includes prospective and concurrent review, discharge planning, work-hardening and return to work programs. The program shall include a sufficient number of injury management facilitators who shall be qualified by reason of education, experience and training to manage an injured employee's medical care by interacting with the employee, treating physician, other healthcare providers and the employer to facilitate the expeditious intervention of medical treatment and an early return to work.

(k) Each managed care organization shall have a sufficient number of injury management facilitators. This number must include at least one resident injury management facilitator with a business office in New Hampshire.

(l) In determining what constitutes a sufficient number of injury management facilitators, the following shall be used to determine compliance:

- (1) The number of employers subscribing to the program;
- (2) The approximate number of employees covered by the program; and
- (3) The average number of cases referred to each injury management facilitator annually;
- (4) At least one in every five injury management facilitators shall be a resident injury management facilitator with a business office in New Hampshire.

~~(m) The managed care organization shall submit the information required in Lab 703.01(l) to the commissioner on an annual basis. An organization seeking initial approval shall provide estimates for the first year of operation with the initial application.~~

~~(m)~~ Injury management facilitators employed or contracted by the managed care organization shall be qualified, with such qualification valid for only five years and subject to requalification an unlimited number of times, in one or more of the following ways:

- (1) By holding a license as a registered nurse issued by the New Hampshire board of nursing and having at least one year of experience in the medical management of workers' compensation claims in New Hampshire or in lieu of experience has completed a training program offered by the department;
- (2) By holding a designation as a certified case manager issued by The Commission on Case Manager Certification, and having at least one year of experience in the medical management of workers' compensations claims in New Hampshire or in lieu of the experience has completed a training program offered by the department;
- (3) By holding a designation as a certified rehabilitation counselor issued by The Commission on Rehabilitation Counselor Certification, and having at least one year of experience in the medical management of workers' compensation claims in New

Hampshire or in lieu of the experience has completed a training program offered by the department;

(4) By holding a designation as a certified disability management specialist issued by The Commission on Disability Management Specialists, and having at least one year of experience in the medical management of workers' compensation claims in New Hampshire or in lieu of the experience has completed a training program offered by the department; or

(5) By holding approval issued by the commissioner of labor and advisory council who after a review of the applicant's background, training and experience in handling New Hampshire workers' compensation cases have determined the applicant is qualified to serve as an injury management facilitator.

(en) The program shall provide an employee with access to a second medical opinion, inside or outside the program, regarding diagnosis or the proper course of treatment, and adequate methods for resolving conflicting medical opinions. Access to a second medical opinion shall be warranted when following an examination and/or diagnosis by a medical provider, the employee remains uncertain about the nature of the injury or the proper course of treatment necessary to cure or alleviate it.

(po) The program shall provide a method for prompt and impartial resolution of questions or disagreements between a healthcare provider and the managed care organization.

Readopt with amendments Lab 703.02, effective 8/1/08 (Document # 9217), to read as follows:

Lab 703.02 Filing.

(a) A proponent of a managed care program in workers' compensation shall file a complete description of the program with the commissioner, who shall review the filing for compliance with the provisions of RSA 281-A:23-a and Lab 703.01.

(b) The filing shall include all information deemed by the proponent to be relevant to a determination of compliance hereunder, including as a minimum the following:

(1) The name and business address of all health care providers included in the network as required in Lab 703.01(d);

(2) ~~A description of~~ The geographic area for which the proponent seeks approval of the managed care program, ~~which~~ shall be no less than the entire state of New Hampshire;

(3) A description of the program's procedure establishing compliance with Lab 703.01(g);

(4) A description of the program's treatment protocols;

(5) A description of the program's in-patient and out-patient case management programs establishing compliance with Lab 703.01(j);

(6) A description of the program's procedures establishing compliance with Lab 703.01(en);

(7) Sample employee information material establishing compliance with Lab 704.02(a)(1); and

(8) Any further information requested by the commissioner in order to determine whether the proposed managed care program complies with the provisions of RSA 281-A:23-a and this chapter.

(c) The format of filing shall include a printed spreadsheet of healthcare providers in the network with columns for county, specialty and provider, and an alphabetical listing at the end with all the providers for each county.

Readopt Lab 703.03 through Lab 703.05, effective 8/1/08 (Document # 9217), to read as follows:

Lab 703.03 Commissioner Approval Process.

(a) After a review of the managed care program, if the commissioner determines a program filed under Lab 703.02 is in compliance, the commissioner shall approve it and provide written notice of such approval to the proponent.

(b) Any program filed under Lab 703.02 shall be deemed approved by the commissioner, unless within 45 days after its filing, the commissioner makes a preliminary determination of noncompliance, specifying in writing the reasons why the program does not comply with RSA 281-A:23-a and Lab 703.01.

(c) If the commissioner determines that the managed care program does not meet the criteria set forth in RSA 281-A:23-a and Lab 703.01, the commissioner shall advise the applicant in writing and specify which criteria have not been met.

(d) The proponent of such program shall have the right to a hearing before the commissioner or the commissioner's authorized representative to contest the preliminary determination.

(e) Upon a preliminary determination approving the program by the commissioner, the proponent shall provide a copy of the program to each member of the advisory council no later than 14 days prior to the next regularly scheduled meeting at which the program is to be acted upon.

Lab 703.04 Advisory Council Process.

(a) A managed care program approved or deemed approved by the commissioner under Lab 703.03 shall be submitted to the advisory council.

(b) Upon receipt of the program, the council shall take the following action:

(1) Consider the ratification of the program at its next regularly scheduled meeting no fewer than 19 days following the commissioner's approval;

(2) Either approve the program or specify its reasons why the program does not meet the requirements of RSA 281-A:23-a and Lab 703.01 in writing; and

(3) Provide the program proponents with the opportunity for a hearing before the council to appeal the non-ratification.

Lab 703.05 Duration of Approval and Review.

(a) Upon its first approval, a managed care organization's approval shall expire 3 years after initial approval.

(b) Upon each subsequent review and re-approval, a managed care organization's approval shall expire 5 years after re-approval.

(c) A managed care organization that seeks re-approval shall submit a full filing, as required by Lab 703.02, 6 months prior to the expiration of its approval.

PART Lab 704 RIGHTS AND RESPONSIBILITIES OF THE PARTIES UNDER MANAGED CARE

Readopt with amendments Lab 704.01, effective 8/1/08 (Document # 9217), to read as follows:

Lab 704.01 Employers.

(a) An employer selecting the managed care option to fulfill its obligations under RSA 281-A:23 shall:

- (1) Inform all employees that it is participating in a managed care program;
- (2) Provide each employee with necessary information **in writing** on how to access the network when he or she suffers a work related injury or illness;
- (3) **For all non-First aid claims, as defined in Lab 502.10, notify the insurer, third party administrator, managed care organization, and department of labor of all injuries to employees; and**
- (4) Cooperate with the insurer and managed care organization in providing temporary alternative duty programs and reinstatement of injured employees in accordance with Lab 504.04 and 504.05.

Readopt with amendment Lab 704.02, effective 8/1/08 (Document # 10038), as amended effective 12/1/11(Document # 10038), to read as follows:

Lab 704.02 Managed Care Organization.

(a) Any person or organization providing managed care services for workers' compensation injuries shall:

- (1) Provide the employer with information for distribution to its employees on how to access the ~~managed care program~~ **network**;
- (2) Promptly respond to all employee inquiries on how and where to obtain treatment within the ~~managed care~~ network; and
- (3) Assign an injury management facilitator to the injured employee's case and advise the injured employee or the employee's representative of the name of the facilitator and the method to be used to contact the facilitator for assistance.

(b) The injury management facilitator shall:

- (1) Act as the case manager for the injured employee;
- (2) **Upon request furnish the employee with** a complete list of the healthcare providers in the network from which the employee may choose a health care professional;

(3) Upon request of the injured employee, furnish a copy of the protocols established by the managed care organization;

(4) Coordinate among the injured employee, health care professionals and insurer to provide the employee with timely, effective and appropriate health care services in order to achieve maximum medical improvement and an expeditious return to work; and

(5) Advise the injured employee of the conditions under which the injured employee may treat outside the network.

(c) Neither a managed care organization nor an injury management facilitator shall perform the duties or functions of an insurance adjuster including, but not limited to determining the causal relation between the injury and employment, and determining entitlement to indemnity or impairment benefits.

(d) Nothing contained in (c) above shall be used to prohibit the managed care organization or injury management facilitator from obtaining any information necessary to the management of the injured employee's treatment and progress to return to work, nor shall any provision in (c) above be construed to relieve any party of the requirements of Lab 503.01 relating to disclosure.

(e) A managed care organization shall file with the commissioner:

(1) A report every ~~3~~ **6** months indicating whether there were any additions or deletions of employers for whom the organization is rendering managed care services; and if so, what those changes were;

(2) A report every 6 months indicating whether there were any additions or deletions to its health care provider network, and if so, what those changes were; and

~~(3) A report every year with the information required by Lab 703.01(m); and~~

~~(4)~~ **(3)** A report whenever there is a substantial change in the managed care organization or health care provider network originally approved by the commissioner, or if there is a loss of a necessary component identified in Lab 703.01.

(f) A managed care organization shall be subject to monitoring by the commissioner under RSA 281-A:23-a, VI(a), for purposes of determining the program's continued compliance with the standards for approval and delivery of service.

(g) A managed care organization whose approval is terminated for any reason shall notify all its client employers by mail within one week of such termination and shall send a copy to the department of labor.

(h) The notice shall include the following words in a conspicuous location:

The required New Hampshire approval for this managed care organization has been terminated. Therefore, you should inform your employees that an injured worker is no longer required to get treatment only within the network for workers' compensation injuries. Instead, the injured worker shall have the right to select his or her own healthcare provider.

Readopt with amendments Lab 704.03, effective 8/1/08 (Document # 9217), to read as follows:

Lab 704.03 Employees.

(a) For purposes of Lab 704.03, concerning the injured employee's obligation to accept treatment within the network and right to treatment outside the network, "network" means only those healthcare providers listed in Lab 703.01(d) and Lab 703.01 (f), as originally approved by the commissioner and ratified by the advisory council or as changed through reports submitted under Lab 704.02 (e).

(b) An employee who receives medical, hospital or remedial care under a workers' compensation managed care program shall:

- (1) Have the right to choose a physician or other health care provider from the network, and to make one change of physician or health care provider within the network at each level of treatment;
- (2) Have the right to privacy during examinations conducted by a health care provider;
- (3) Have the right to obtain a copy of the protocols established by the managed care organization;
- (4) Have the right to treatment outside the network in accordance with the provisions of Lab 703.01(g);
- (5) Have the right to request a second opinion relative to diagnosis or course of treatment in accordance with Lab 703.01(e);
- (6) Have the right to request an independent medical opinion in accordance with Lab 705.01;
- (7) Have the right to subsequent independent medical opinions, as provided in RSA 281-A:38-a;
- (8) Have the obligation to accept treatment within the healthcare provider network, if the services are provided therein **as described in Lab 703.01 (d) and (f)**; and
- (9) Have the obligation to cooperate with the managed care organization, insurer and employer with respect to temporary alternative duty assignments and reinstatement to employment as provided in Lab 504.04 and 504.05.

Readopt with amendment Lab 704.04, effective 8/1/08 (Document # 9217), as amended (Document # 10038), effective 12/1/11 (Document # 10038), to read as follows:

Lab 704.04 Carriers, Self-Insurers and their Representatives.

- (a) The carrier or self-insurer providing benefits under RSA 281-A shall:
- (1) Have the responsibility to determine the causal relationship between the injury and the employee's employment;
 - (2) Have the responsibility to review and authorize or deny payment of all related medical expenses within 30 days of its receipt of the billing;
 - (3) Have the responsibility for issuing any denials for treatment or benefits presented as associated with the employee's injuries;

- (4) Have the responsibility to request and schedule any independent medical examinations in accordance with Lab 506.01(g);
- (5) Have the responsibility to pay for an independent medical examination allowed to the injured employee under the provisions or RSA 281-A:38-a, and Lab 705.03; and
- (6) Have the responsibility to pay only for charges for care rendered by the health care providers within the network approved by the commissioner, except for treatment outside the network specifically authorized or directed by RSA 281-A:23-a, I(b), or by these rules.

(b) Any carrier, or self-insured employer or employer group, or third party administrator that provided or paid or gave direction and guidance to Injury Management Facilitators who worked with their injured workers prior to July 1, 2011, may continue to operate in that manner. Such Injury Management Facilitators shall be certified in accordance with Lab 703.01(am).

Readopt Lab 705, effective 8/1/08 (Document # 9217), cited and to read as follows:

PART Lab 705 PROCEDURE TO REQUEST AN INDEPENDENT MEDICAL EXAMINATION

Lab 705.01 First Request to be Granted. If an injured employee who is covered by a managed care program is dissatisfied with a determination made by the program relating to compensability, degree of disability or degree of impairment arising from an injury, the injured employee may apply to the commissioner for authorization to obtain an independent examination and report thereof by a health care provider of the injured employee's choice. The commissioner shall grant one such authorization as a matter of course.

Lab 705.02 Subsequent Requests. Authorization for additional independent examination regarding the same injury shall be granted only if the commissioner finds that circumstances exist which cast reasonable doubt on the accuracy of the report of the first independent examination based upon the circumstances of the particular case and any written material which contradicts the first independent exam or the circumstances surrounding that exam.

Lab 705.03 Payment for Provider's Services. The health care provider conducting an independent examination authorized by the commissioner in Lab 705.01 shall be entitled to a reasonable fee as provided under RSA 281-A:38-a which shall be paid by the employer or the employer's insurance carrier. Nothing in this section shall be construed to prevent an injured employee from obtaining an examination by a health care provider of the injured employee's choice at the employee's expense.

Repeal Lab 706, effective 8/1/08 (Document # 9217), as follows:

PART Lab 706 ~~ADJUSTMENT OF BENEFITS~~ RESERVE FOR FUTURE USE

~~Lab 706.01 Procedure for Requesting Cessation or Adjustment of Benefits.~~

~~(a) If the health care provider treating an injured employee covered by a managed care program certifies that the employee can return to regular work duty on a full time basis or identifies specific restrictions permitting a return to modified work, the employer, employer's insurance carrier or self insurer shall request approval of the commissioner prior to terminating or adjusting benefits by submitting the following:~~

- ~~(1) A request for permission to terminate or adjust benefits in writing;~~

- ~~(2) A copy of the medical documentation from all treating health care providers that when taken as a whole supports the request, and a statement that the employee or the employee's representative has been provided with the request and supporting documentation; and~~
- ~~(3) A copy of a notice to the employee or the employee's representative, notifying the employee of the employee's right to apply to the commissioner for an independent medical examination and report by a healthcare provider of the employee's choice, and the time limit for making such an application as provided in (b) below.~~
- ~~(b) Employees applying for an independent medical examination shall do so within 7 days after receipt of the notice required in (a)(3) above. Upon receipt of such an application, the commissioner shall grant approval in accordance with RSA 281-A:38-a and shall notify the employee, the employer, insurance carrier or self insurer of the action taken. No action on the request for termination or adjustment of benefits shall be taken for 10 days thereafter.~~
- ~~(c) The commissioner or the commissioner's representative shall review the request for termination or adjustment of benefits within 5 working days after the expiration of the deadline for application for an independent medical examination if no such application has been received, or if such an application has been granted, within 5 working days after the expiration of the 10-day no-action period prescribed in (b) above.~~
- ~~——(d) The review shall be conducted using the criteria specified in Lab 510.02.~~
- ~~(e) The commissioner shall notify all parties of the decision. Any party aggrieved by the decision may request a hearing.~~

Appendix

Rule	Specific State Statute which the Rule Implements
Lab 701	RSA 281-A:23-a
Lab 702	RSA 281-A:23-a
Lab 703	RSA 281-A:38-a
Lab 704	RSA 281-A:23-a
Lab 705	RSA 281-A:38-a
Lab 706.01 (a)(Repealed)	RSA 281-A:48
Lab 706.01 (b)(Repealed)	RSA 281-A: 38-a
Lab 706.01 (c), (d), (e)(Repealed)	RSA 281-A:48