ADVISORY COUNCIL ON WORKERS' COMPENSATION

2012 REPORT

Advisory Council Members

Thomas W. Callahan, Chair
Orchard Medical Management, LLC

Margaret Crouch, Vice Chair
Travelers Insurance

Kathryn J. Barger, WC Director
New Hampshire Department of Labor

Representative Gary Daniels
New Hampshire House of Representatives

Douglas M. Goumas, M.D.
The Orthopaedic Center

William J. McQuillen
Professional Firefighters of New Hampshire

Marian Mitchell
Comp-Sigma Limited

Deborah Stone
New Hampshire Department of Insurance

ADVISORY COUNCIL
ON
WORKERS' COMPENSATION

2012 REPORT

TABLE OF CONTENTS

I. Introduction

In 2012 the Workers' Compensation Advisory Council met nine times, again focusing on rising medical costs. The Council created draft legislation (see attached) from the numerous motions passed in 2012.

At the last meeting of 2012, a motion was passed to create a subcommittee to continue to study other methods and approaches to address rising medical costs. This subcommittee includes some members of the Council as well as interested stakeholders in the hopes of reaching a consensus solution to this issue.

The members of the subcommittee include:

Thomas Callahan	Orchard Medical Management, LLC
Margaret Crouch	Travelers Insurance Company
Douglas Goumas, MD	The Orthopaedic Center
Kathryn Barger	NH Department of Labor
William McQuillen	Professional Firefighters of NH
Deborah Stone	NH Department of Insurance
Joseph Pachman, MD	Liberty Mutual
David McClung	NH Hospital Association
David Juvet	NH Business & Industry Association
Peter McArdle	NH Association of Domestic Insurance Companies
Douglas Grauel, Esq.	Grauel Law Offices, PLLC
Gary Woods, MD	NH Medical Society
Marc Lacroix	Physical Therapy Association

The Council also encouraged the Department of Labor to create a link on its website to the new Chronic Pain and Opioid Treatment Guidelines on the New Hampshire Medical Society's and the New Hampshire Board of Medicine's websites.

A summary of the Council's actions on Managed Care Certifications is also included.

Respectively submitted,

Tom Callahan, Chair
Workers' Compensation Advisory Council

II. Workers' Compensation Managed Care

There are currently seven (7) approved Managed Care Organizations in New Hampshire that provide case management services statewide. Approval to operate a managed care organization in New Hampshire is granted by the Workers' Compensation Advisory Council on the recommendation of the Department of Labor.

The program criteria and approval process is outlined in the Workers' Compensation Managed Care rules, LAB 703. The organization is required to submit to the Department of Labor a copy of their managed care program. The Commissioner reviews the program criteria to confirm that it meets the necessary components as specified in managed care rules. Additionally, the commissioner shall review each managed care program for purposes of determining the program's continued compliance with the standards for approval and delivery of service prior to the expiration of 3 years from the date the program's approval was ratified by the advisory council. Subsequent reviews shall take place at least once every 5 years thereafter, or whenever the commissioner determines that such a review is required. There are two (2) managed care organizations coming up for renewal in 2013.

Managed Care Organizations offer the services of an injury management facilitator (IMF) and a comprehensive network of medical providers to assist the employee with their workers' compensation claim. The IMF is able to provide education on the workers' compensation process to employers and employees. These services are the keys to successful implementation of managed care.

Injury management facilitators, who are approved by the WC Advisory Council, provide case management to the injured employee. The IMF's role is to coordinate among the injured employee, health care professional 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. They must follow the protocols of the Managed Care Organization who has retained their services.

In 2012, the WC Advisory Council approved three (3) new Injury Management Facilitators bringing the total of approved IMF's to 76. The WC Advisory Council also recertified twenty-four (24) Injury Management Facilitators under LAB 703 as amended.

The Department of Labor closely monitors the performance and impact of managed care organizations in New Hampshire. Quarterly meetings with the managers of the organizations are excellent opportunities to address Department of Labor concerns. Injury management facilitators are required to participate in training seminars and/or use training tapes on the laws and rules of Managed Care and benefit provisions of the Workers' Compensation law.

DRAFT

281-A:23 Medical, Hospital, and Remedial Care –

VII. Pharmacies, including mail-order pharmacies, shall substitute generically equivalent drug products for all legend and non-legend prescriptions unless the prescribing practitioner handwrites "medically necessary" on each paper prescription, or uses electronic indications when transmitted electronically, or gives instructions when transmitted orally that the brand name drug product is medically necessary.

DRAFT

281-A:23-c Employer Selection of Health Care Provider during First 10 Days –

During the first 10 days following the employee's notice to the employer of an injury with the intention to seek medical care, an employer, employer's insurance carrier or self-insurer that is subject to the provisions of this chapter may satisfy the requirements and provisions of RSA 281-A:23 and the employee's rights under that section by selecting a health care provider to treat the employee during those first 10 days.

DRAFT

281-A:23-d 90-day Employer Preferred Provider Network –

I. (a) During the first 90 days following the employee's notice to the employer of an injury with the intention to seek medical care, an employer, employer's insurance carrier or self-insurer that is subject to the provisions of this chapter may satisfy the requirements and provisions of RSA 281-A:23 and the employee's rights under that section by providing a Preferred Provider Network which has been approved by the commissioner, within which the employee must obtain medical, surgical, and hospital services, remedial care, and nursing that the Preferred Provider Network provides.

(b) The employer, employer's insurance carrier or self-insurer must educate and inform the injured employee about the employee's rights and obligations while receiving treatment in the Preferred Provider Network, including the employee's right to resolution of medical disputes.

II. A Preferred Provider Network shall not be utilized by an employer unless the employer's use of the Preferred Provider Network has been approved as specified in this section. A Preferred Provider Network shall not be approved unless the commissioner finds that:

(a) The Preferred Provider Network includes providers who have experience and expertise in treating work-related injuries.

(b) The Preferred Provider Network of health care providers is sufficiently comprehensive with respect to geography based on the employer's work site or work sites, and has a minimum of two health care providers in each medical specialty included in the network. (c) 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.

(d) The Preferred Provider Network provides for acceptable quality assurance measures.

III. (a) The employee shall have the right to treatment and aids outside of the Preferred Provider Network:

(1) if necessary treatment or aids cannot be provided within the Preferred Provider Network, or

(2) if emergency circumstances prohibit use of the Preferred Provider Network, or

(3) if an injured employee has been treated within the prior 6 months for a prior recurrence or aggravation of the work injury by a provider who is not a member of the Preferred Provider Network, as long as such provider complies with all the terms, conditions, protocols, referral procedures, and levels of reimbursement established by the Preferred Provider Network, or

(4) if the injured employee's residence is located more than 60 miles of travel from the nearest relevant medical care provider in the Preferred Provider Network; or

(5) in such other circumstances as the commissioner may find.

(b) The employee shall have reasonable access to a second medical opinion, inside or outside the Preferred Provider Network, regarding diagnosis or the proper course of treatment, and adequate methods for resolving conflicting medical opinion.
If the employee is dissatisfied with a determination made by a health care provider within the Preferred Provider Network relating to compensability, degree of disability or degree of impairment arising from an injury, the employee may apply to the commissioner for authorization to obtain an independent examination, in the manner of RSA 281-A:38-a.

IV. In addition to approval by the commissioner as required under paragraph II, approval of a Preferred Provider Network shall require an affirmative vote of ratification of such approval by the advisory council on workers' compensation, established under RSA 281-A:62, using the same time limits as for approval of managed care programs under RSA 281-A:23-a.

V. The approval of a Preferred Provider Network shall expire after 5 years, but may be offered for approval again at any time, before or after such expiration. Notice of any change in the providers within, or adding a medical specialty to, an approved Preferred Provider Network must be sent to the commissioner within ten days of such change. The commissioner shall have the power to revoke approval of a Preferred Provider Network if at any time it fails to meet the requirements of section II above.

VI. The commissioner shall have the power to adopt rules under RSA 541-A relative to the approval and operation of Preferred Provider Networks.

VII. The advisory council on workers' compensation established under RSA 281-A:62 shall review the effectiveness of Preferred Provider Networks and issue a report within 3 years of the effective date of this legislation. The report shall be submitted to the president of the senate, the speaker of the house, the governor, the commissioner of labor and the commissioner of insurance. During such 3-year period, only employers who have an established place of business in the counties of Hillsborough, Rockingham and Merrimack shall be eligible to utilize a Preferred Provider Network specified in this section.

DRAFT

281-A:23-e Pharmacy Benefits Management Programs –

I. An employer, employer's insurance carrier or self-insurer that is subject to the provisions of this chapter may satisfy the requirements and provisions of RSA 281-A:23 and the employee's rights to medicine under that section by providing a pharmacy benefits management program which has been approved by the commissioner.

II. A pharmacy benefits management program shall not be approved unless the commissioner finds that:

(a) The program provides for educating the injured employee about the proper use of the network to obtain medicines.

(b) The program is sufficiently comprehensive with respect to geography, and has live assistance available by phone and internet at all times.

(c) The program allows the injured employee to obtain medicines outside the program if the necessary medicine cannot be provided within the program, or if emergency circumstances prohibit the use of the program, or in such other circumstances as the commissioner may find.

(d) The program includes a process for determining professional qualifications of pharmacies in the program.

(e) The program provides for acceptable quality assurance measures.

(f) The program is accredited by the URAC organization or an equivalent organization.

(g) The program does not require the injured worker to obtain medicines by mail, except at the worker's option.

(h) The program provides that a first fill of medicine prescribed at initial treatment made through the program is at no cost to the injured employee.

III. In addition to approval by the commissioner as required under paragraph II, approval of a pharmacy benefits management program shall require an affirmative vote of ratification of such approval by the advisory council on workers' compensation, established under RSA 281-A:62, in the same manner as approval of managed care programs under RSA 281-A:23-a. Such approval shall expire in five years and be subject to re-approval.

IV. Every pharmacy benefits management program shall be subject to the same oversight and review by the commissioner as managed care programs under RSA 281-A:23-a.

DRAFT—

281-A:24 Payment for Reasonable Value of Services. –

I. ~~The employer or the employer's insurance carrier shall pay the full amount of the health care provider's bill unless the employer or employer's insurance carrier can show just cause as to why the total amount should not be paid.~~ **In the absence of any contract setting reimbursement rate the employer or the employer's insurance carrier shall pay the physician, surgeon, or medical facility a reasonable fee for services and reimbursement for necessary services. The employer or its insurance carrier shall have the burden to show what amount is reasonable in the event of a dispute.**

Effort shall be made to resolve any dispute as to the reasonable value of service prior to applying to the commissioner for resolution of such a dispute. Whenever an injured employee receives medical and hospital service or other remedial care under the provisions of this chapter and a dispute arises between the employer and the person, firm, or corporation rendering such service or care as to the reasonable value of the service or care, the commissioner shall have exclusive jurisdiction to determine the reasonable value of such service or care. Following the commissioner's determination, any interested party may petition for a hearing and all interested parties shall be entitled to notice and hearing if it is determined that all reasonable efforts to resolve the dispute have failed. The commissioner or the commissioner's authorized representative shall make a finding as to the reasonable value of such services or care rendered, and such findings shall be final.