Introduction and Overview of HCO Program

To meet the requirements of Article 8 §9771.70, First Health has designed this manual for The **First Health**® Network[∇] providers participating in The First Health/CompAmerica certified Health Care Organization (HCO).

What is an HCO?
A workers' compensation Health Care Organization (HCO) is an organization that has been certified by the State of California Division of Workers' Compensation to provide health care to injured workers. An HCO has been certified by the State, and The **First Health**® Network is an integral part of the certified HCO Program. The **First Health**® Network has met specific access and health care delivery standards for providers in the HCO program. This manual outlines the requirements of Network providers who are critical to the success of this HCO Program.

First Health is pleased to bring you another opportunity to receive more patients as a network provider. The goal of the HCO is to promote a cooperative effort between employees, employers and the HCO toward a successful and timely return-to-work for the injured worker.

Why participate in an HCO?
Injured workers choose to enroll in an HCO. As a participating provider in The **First Health**® Network, these enrolled injured employees will be directed to you, and they must use HCO providers for any medical treatment for a specified length of time (usually up to 180 days). Enrollees are entitled to at least one change of physician for an injury if requested. Enrollees may also request a second opinion but are only allowed one.

What is included in an HCO program?
- The certified entity will enroll injured workers for various employers;
- The certified entity will assign each enrollee a Primary Treating Provider (PTP) from The **First Health**® Network at the time of injury;
- The certified entity will distribute HCO information to the injured worker to help him/her understand his/her responsibilities in the HCO. The HCO enrollee will also provide information to Network providers on who to contact during the course of the treatment. The certified entity will provide utilization review and case management services;
- The certified entity has established and will administer, as appropriate, treatment guidelines;
- Providers in The **First Health**® Network are the only HCO providers available to the enrollee;
- Providers will be instructed to forward complaints or grievances to the certified entity;
- All state-required reporting will be completed by the certified entity;
- The certified entity's clients will send payments to network providers.

[∇] (The First Health Network includes: First Health, CCN, CompAmerica, Anchor Medical Group)

Definitions

Primary Treating Physician (PTP) – The physician primarily responsible for providing and managing the care of an injured employee in accordance with Labor Code Section 9785.5 who has enrolled in the HCO.

Consulting Specialist – The consulting specialist provides care to the injured employee after referral from a PTP.

Employer – The employer as defined in Section 3300 of the Labor Code.

HCO enrollee – The injured worker who is eligible to receive services from the HCO.

Health Care Organization (HCO) – Any organization certified as an HCO by the State of California Division of Workers' Compensation.

Participating Provider – A provider who is contracted and in good standing in The **First Health**® Network$^{\nabla}$.

Utilization Review – A system used to manage costs and improve patient care and decision making through case by case assessments of the frequency, duration, level and appropriateness of medical care and services to determine whether medical treatment is or was reasonably required to cure or relieve the effects of the injury.

Utilization review includes, but is not limited to, the review of requests for authorization and the review of bills for medical services for the purpose of determining whether medical services provided were reasonably required to cure or relieve the injury, by either an insurer or a third party acting on an insurer's behalf. Utilization review does not include bill review for the purpose of determining whether the medical services rendered were accurately billed, and does not include any system, program, or activity in connection with making decisions concerning whether a person has sustained an injury which is compensable under Division 4 (commencing with section 3200) of the Labor Code.

HCO Provider Responsibilities

Patient Care - Access, Referrals and Support Services

The PTP is responsible for rendering initial care to the injured employee and assessing whether further care may be necessary. The PTP must initiate clinical review as defined in the injured worker instruction sheet that is presented at the time of the first visit. A PTP will be assigned for each HCO enrollee.

Appointments and Waiting Times

Injured employees requiring urgent care should be seen within 24 hours of the request. Non-urgent care appointments should be accommodated within the shortest reasonable timeframe depending on the injured employee's medical problem. Providers should contact the certified entity immediately if they are not able to reasonably accommodate a referred HCO injured employee for either urgent or non-urgent care so that another PTP may be assigned.

Acceptable waiting time in a provider's office or clinic should not exceed reasonable community standards of more than 30-45 minutes. Appointment time with the provider should allow for adequate physician/injured employee interaction from 30-45 minutes for the initial exam and/or routine follow-up care visits lasting approximately 15 – 30 minutes.

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Referrals to Consulting Specialists

PTPs should make timely referrals to consulting specialists participating in The **First Health**® Network after contacting the certified entity's case management department and providing notification of the need for a specialist referral.

Limitation on Physical Therapy, Chiropractic and Occupation Therapy Visits

Workers compensation statues currently state that notwithstanding the medical treatment utilization schedule or the guidelines set forth in the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, for injuries occurring on and after January 1, 2004, an employee shall be entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury.

Continuity of Care

The PTP should obtain reports from the consulting specialists to ensure the continuity of care is consistent with the appropriate return to work plan.

Emergency Care

Emergency care includes those health care services provided to evaluate and treat medical conditions of recent onset and severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that urgent and/or unscheduled medical care is required.

Change of Physician, Chiropractors, Acupuncture Care

Injured employees are entitled to at least one change of physician once referred. HCO enrollees are entitled to referral to a chiropractor or acupuncture care within five days of making this request, as appropriate. The certified entity will make these referrals.

All Referrals

The certified entity will arrange all referrals by using providers participating in The **First Health**® Network$^{\nabla}$.

Please notify the certified entity's case management department if injured employees request a change of physician or a referral to chiropractors, acupuncturists or specialty care.

Availability of Interpreter Services, Occupational Medicine Expertise

Injured employees are entitled to interpreter services. Participating providers should contact the certified entity to request these services for injured employees as soon as an HCO enrollee requests them or in the event that you believe the HCO enrollee needs an interpreter in order to properly communicate with the injured employee about his/her medical care.

Occupational medicine expertise is available through the HCO. Providers should contact the certified entity's case management department to request these services if needed in making return-to-work, disability, impairment, modified duty decisions, etc.

Clinical Management Interface

Providers are expected to cooperate with the certified entity's case management department in order to comply with utilization review policies and protocols. Providers should formulate return-to-work plans in conjunction with case managers. These plans may include development of work restrictions, disability reports, communication with employers about availability of modified duty, etc.

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The certified entity's case managers will assist PTPs in obtaining exposure data, job descriptions, availability of modified duty opportunities in a specific work setting used to formulate a return-to-work plan for the HCO enrollee.

Other Provider Requirements - Quality, Credentialing, Records Maintenance, and Bill Submission

Licenses and Certifications - PTPs and consulting specialists are responsible for maintaining all appropriate licenses and certifications as required by state and federal law and in accordance with the credentialing requirements of The **First Health**® Network. Provider contracts require reporting of any material change in license status or in certifications required for Network participation.

Medical Records – Providers must maintain all appropriate records as required by law for at least 5 years. First Health or the California Workers' Compensation Division may request, during normal business hours, copies of documentation associated with care delivered to injured workers enrolled in the program.

Medical Reports – Providers must complete and submit timely, appropriate reports as required by law. At a minimum, reports must include the following:

- Injured worker's name and address;
- Injured worker's medical history as obtained and reviewed by the physician;
- The physician's findings on the examination;
- The planned course, scope, frequency and duration of the treatment;
- A planned return-to-work date;
- PIR/MMI ratings, if appropriate, or functional capacity of the injured employee.

Medical/Legal Reports – Under Labor Code Section 4628 of the Workers' Compensation and Insurance reference, providers may be requested to submit Medical/Legal Reports. When requested, providers must provide medical/legal reports in a timely manner. The purpose of these reports is to provide an objective evaluation on the employee's medical condition for a contested claim. At a minimum, reports must include the following:

- Injured worker's medical condition at the time of the report;
- The cause and treatment of the medical condition;
- The existence, nature, duration or extent of TTD, PTD, impairment and/or disability caused by the employee's medical condition;
- The employee's medical eligibility for rehabilitation services.

All Medical/Legal reports will be reimbursed per the allowable California Medical/Legal fee schedule. The California reimbursement schedule for these reports are noted under Title 8, California Code of Regulations, Article 5.6 Fees for Medical/Legal expenses.

Bill Submission - Providers must submit bills to the designated client/payer in a reasonable amount of time. The certified entity will advise where to send bills in order to expedite payment. Bills should be submitted no later than 60 days after rendering initial service to the HCO enrollee.

Payment - Providers will receive payment within 30 days after of receipt of a complete bill. Payment will be based on your contract with The **First Health**® Network. No co-payments are required or may be requested of HCO enrollees. Do not balance bill the HCO injured employee. Contact the payer with billing questions or contact First Health's Provider Services number with questions regarding your First Health contract.

Grievances

The certified entity receives and resolves all issues, complaints or grievances pertaining to services provided under the HCO. This process meets the requirements of the California HCO to assist providers in submitting and resolving formal and informal grievances.

You may contact the certified entity at the number on the information provided to you by the injured worker regarding any issues pertaining to clients or injured employees participating in the certified entity's HCO program. The certified entity may contact you and will expect assistance in resolving any issues pertaining to an HCO enrollee. First Health will work in coordination with the certified entity in resolving grievances, as appropriate.

If an Employee/Employer/Provider has a grievance about issues not directly related to medical and health services, they may contact the Certified Entity through the 800#. All attempts will be made to resolve/correct the grievance by telephone.

If the issue is not resolved on that telephone call, the Certified Entity will mail the employee/employer/provider a Grievance Form. This form is submitted to the Certified Entity to begin the resolution process. As long as all documents or records necessary to reach a decision on the grievance have been received, a final determination on the grievance shall be made within thirty (30) days after the grievance is filed.

The Employee/Employer/Provider may request assistance with a grievance from the California Administrative Director/DWC Managed Care Program.

Grievances involving medical treatment decisions are handled using a different process.

This process will be outlined when such a grievance is filed.

Grievances and/or issues with the Network are forwarded to First Health grievance liaison. The Certified Entity liaison records the relevant information, including the caller's name and number and the nature of the grievance and forwards the information to First Health. Upon receipt of the resolution, First Health forwards the resolution information to the Certified Entity.

Provider Services and Training

First Health believes providers should be well informed about The **First Health**® Network in general and the California HCO Program in particular. Please contact us by phone or via our website to get answers to your questions about Network participation. Our website address is:

http://www.firsthealth.com/NETWORKSERVICES/SelfRegister.jsp. You can order a confidential password either by calling Provider Services or by going directly to the website.

Telephone Communications

We have staff specialty teams who are available via a toll-free telephone number to respond to your inquiries.

For hospital and providers, First Health assigns staff to designated regions of the country in order to facilitate good communication with your hospital and office personnel and promote provider satisfaction. The number to call for Provider Services is (800) 937-6824.

Printed Materials and Website Access

Upon joining the network, you will receive this manual along with other correspondence from First Health relating to your participation in The **First Health**® Network. Should you need further assistance, please contact the Provider Services' staff at the number listed above.

We strongly encourage all providers participating in The **First Health**® Network to ask for a password to access the Provider section of the First Health website. This manual, which may be updated and changed as California Division of Workers' Compensation rules may require, is available in the Provider section of the First Health website.

Please call Provider Services at (800) 937-6824 and ask to be mailed an initial password for website access.