Provider Reference Manual
Introduction and Overview of Medical Provider Networks (MPNs)

To meet the requirements of SB899, First Health has designed this manual for The **First Health**® Network providers▽ participating in one of the certified Medical Provider Networks (MPNs) being accessed by First Health workers' compensation clients.

What is an MPN?
An MPN is network of providers that has been certified by the State of California Division of Workers' Compensation to provide health care to injured workers. The MNP has been certified by the State, and The **First Health**® Network providers are an integral part of the certified MPN. The **FirstHealth**® Network has met specific access and health care delivery standards for providers in the MPN. This manual outlines the requirements of Network providers who are critical to the success of the MPN.

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

You can locate a list of all state approved MPNs at the following web-site:
http://www.dir.ca.gov/dwc/MPN/DWC_MPN_Main.html

Why participate in an MPN?
SB899 allows employers or insurers in the State of California to submit a list of medical providers for use by injured workers. Employers who chose to implement an MPN as of January 1, 2005 will have control of direction and channeling of an injured worker's care for the entire life of the claim (as opposed to the current 30 days or 180 days for employers accessing an HCO). As a participating provider in The **First Health**® Network, these injured workers will be directed to you, and they must use MPN providers for all medical treatment for the entire life of their claim. Workers are entitled to a change of physician for an injury if requested.

Configuration of an MPN
First Health offers its clients access to its California HCO Primary and Select Networks for their MPN as the HCO configurations is deemed approved by the State of California as an MPN offering. A description of how the two networks were designed is available via the First Health website under the document called "SB899 Methodology Network Criteria".

In addition, some workers' compensation clients have elected to "design their own custom Network" using providers participating in The **First Health**® Network. Under the certified entity's custom network, the client has defined their process for network configuration. Please refer to the client listing for specific reference to where to locate this information.

Definitions

Primary Treating Physician (PTP) – The physician primarily responsible for providing and managing the care of an injured workers in accordance with Labor Code Section 9785.5.
Consulting Specialist – The consulting specialist provides care to the injured worker after referral from a PTP.
Employer – The employer as defined in Section 3300 of the Labor Code.
Medical Provider Network – An organization certified as an MPN by the State of California Division of Workers' Compensation.

∇ (The First Health Network is comprised of First Health, CCN, CompAmerica and Anchor Medical Group)

Participating Provider – A provider who is contracted and in good standing in The **First Health**® Network. Providers may participate in more than one First Health MPN.

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.

Provider Responsibilities

Patient Care - Access, Referrals and Support Services

The PTP is responsible for rendering initial care to the injured worker 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.

Appointments and Waiting Times

Injured workers requiring urgent care should be seen within 24 hours of the request.

Non-urgent care appointments for initial treatment of an injury should be accommodated within 3 business days of the employer or insurer's request for treatment. Providers should contact the certified entity immediately if they are not able to reasonably accommodate a referred injured worker for either urgent or non-urgent care so that another PTP may be assigned.

Non-urgent care appointments for specialist care treatment should be accommodated within 20 business days of the employers or insurer's request for specialist care treatment. Providers should contact the certified entity immediately if they are not able

to reasonably accommodate a referred injured worker for specialty care so that referral to another specialist within the MPN may take place.

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 worker interaction from 30-45 minutes for the initial exam and/or routine follow-up care visits lasting approximately 15 – 30 minutes.

Referrals to Consulting Specialists

PTPs should make timely referrals to consulting specialists participating in the employer or insurer's MPN 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

Employers will be required to have a continuity of care plan in the event should a provider terminated from a certified MPN.

Should you terminate your participation in The **First Health**® Network or the MPN, an injured worker, the insurer or the employer may request you remain the provider of care if the injured worker was receiving services from you that meet one of the following conditions:

1) An acute condition. An "acute condition" is defined as a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of treatment must be provided for the duration of the acute condition.
2) A serious chronic condition. A "serious chronic condition" is defined as a medical condition due to a disease, illness, other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing medical treatment to maintain remission or prevent deterioration. Completion of treatment must be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the insurer or employer in consultation with the injured worker and the terminated provider and consistent with good professional practice. Completion of treatment for a serious chronic condition may not exceed 12 months from the contract termination date.
3) A terminal illness. A "terminal illness" is defined as an incurable or irreversible condition that has a high probability of causing death within on year or less. Completion of treatment must be provided for the duration of a terminal illness.

4) Performance of a surgery or other procedure that is authorized by the insurer or employer as part of a documented course of treatment and has been recommended and document by the provider to occur within 180 days of the contract's termination date.

An employer or insurer may require you to treat an injured worker at the same contractual terms, conditions and rates that were imposed prior to the contract termination date. If you do not agree to comply with the terms, conditions and rates, the employer or insurer is not required to authorize treatment with you (the terminated provider) beyond the date of the provider's contract termination date.

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
Injured workers are entitled to change physicians within the MPN at any time. Please notify the certified entity's case management department if injured worker request a change of physician.

Second and Third Opinions
If an injured worker disputes either the diagnosis or the treatment prescribed by the treating physician, the injured worker may seek the opinion of another physician in the MPN. If the injured worker disputes the diagnosis of treatment prescribed by the second physician, the worker may seek the opinion of a third physician in the MPN. If after the third physician's opinion, the treatment or diagnostic service remains disputed, the injured worker may request Independent Medical Review (IMR) through the Division of Workers' Compensation (DWC). Please notify the certified entity's case management department if injured worker request an IMR.

All Referrals
All referrals will need to be made to providers participating in the employer, insurer or First Health MPN. Please notify the certified entity's case management department if injured workers request a change of physician or a referral to chiropractors, acupuncturists or specialty care.

Availability of Interpreter Services, Occupational Medicine Expertise
Injured workers are entitled to interpreter services. Participating providers should contact the certified entity to request these services for injured workers as soon as an injured workers requests them or in the event that you believe the injured workers needs an interpreter in order to properly communicate with the injured workers about his/her medical care.

Occupational medicine expertise is available through the certified MPN. 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.

Physical Impairment (Apportionment)
SB899 sets for that providers shall incorporate the descriptions and measurements of physical impairments and the corresponding percentages of impairments published in the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th Edition). We encourage you to seek any additional training that you may need to meet these new state requirements.

New regulations on apportionment are contained in Labor Code sec. 4663 and sec. 4664. You may obtain a complete description of these sections at the DWC web site:
http://www.dir.ca.gov/dwc/wcreformindex.html
Significant changes to providers include obtaining additional history from the injured worker and submitting complete and accurate reports You should be aware of the following new regulations: 1) apportionment of permanent disability shall be based on causation; 2) reports addressing permanent disability shall address the issue of causation of the permanent disability; 3) in order for a provider report to be considered complete, it must include an apportionment determination; 4) an employee who claims an industrial injury shall, upon request, disclose all previous permanent disabilities or physical impairments.

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.

At the current time, the American College of Occupational and Environmental Medicine (ACOEM) guidelines are considered presumptively correct on the issue of extent and scope of medical treatment. Should you need more information about ACOEM guidelines, please visit the ACOEM website at www.acoem.org. For injuries not covered by ACOEM or by guidelines adopted by the DWC, authorized treatment must be in accordance with other evidence based medical treatment guidelines generally recognized by the national medical community and that are scientifically based.

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.

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 inured workers.

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

Quality Review Program - In addition to the standard First Health network quality programs, First Health may also review your compliance with the requirements applicable to you as a provider of services within an MPN. First Health reserves the right to remove your name as a participating provider in a First Health MPN based on non-compliance with these requirements or if there is evidence to substantiate a quality issue that may make you ineligible for participation. You may be eligible for reinstatement if these issues are resolved. All quality review programs will be conducted in compliance with the Medical Review and Quality Assessment provisions of your provider agreement.

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 workers.

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.

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 injured workers. Do not balance bill the injured workers. Contact the payer with billing questions or contact First Health's Provider Services number with questions regarding your First Health contract.

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 workers participating in the certified MPN. The certified entity may contact you and will expect assistance in resolving any issues pertaining to an injured workers. 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 First Health MPNs 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. The number to call for Provider Services is (800) 937-6824.

Website Access

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 and ask to be mailed an initial password for website access.