genex℠
CHOICE Provider Network
A division of Genex Services, LLC

CHOICE PROVIDER MANUAL

PREFERRED PROVIDER NETWORK

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Introduction

Welcome to ***CHOICE Provider Network***, a division of Genex Services, LLC. *CHOICE* presents a workers' compensation health care delivery system carefully designed to significantly reduce the cost of health care services for the injured worker. We offer employers a select network of physicians, hospitals, occupational clinics and ancillary services all of which meet the ***CHOICE Provider Network*** standard of excellence. At *CHOICE*, we believe that one of the best ways to ensure the cost-effective delivery of quality health care is to identify qualified, knowledgeable providers who practice prudent health care management and are committed to quality, cost-effective health care and a shared return to work philosophy.

It is our goal to ensure that each employee with a work-related injury or illness receives prompt and appropriate health care services. Our medical management process involves working directly with the employee as well as the provider who can facilitate many aspects of the treatment, recovery, and return to work for the employee.

At ***CHOICE Provider Network***, we believe that the key to a successful program is a well-developed working relationship with our providers and ongoing education and communication. We value your commitment to provide health care to members, and we look forward to helping you serve our employers and their employees.

Please take the time to review the information and materials contained in this manual. If you have any questions, or we can assist you in any way, please do not hesitate to contact a ***CHOICE*** **Provider Network** representative.

We are never more than a phone call away!

(813) 282-9801
(888) 823-5377
or
www.genexservices.com

CHOICE Provider Network
1408 N. Westshore Boulevard
Suite 700
Tampa, FL 33607

Glossary of Terms & Definitions

Agency: the Agency for Health Care Administration (AHCA).

Alternate Medical Care: a change in treatment or health care provider.

Carrier: refers to the insurance carrier, self-insurance fund, or individually self-insured employer or assessable mutual insurer.

Certified Health Care Provider: a health care provider who has been certified by the agency or who has entered into an agreement with a licensed managed care organization to provide treatment to injured workers. Certification of such health care providers must include documentation that the health care provider has read and is familiar with the portions of the statute, impairment guides, practice parameters, protocols of treatment, and rules which govern the provision of remedial treatment, care, and attendance.

Complaint: any dissatisfaction expressed by an injured worker concerning an insurer's workers' compensation managed care arrangement.

Compensable: a determination by a carrier or judge of compensation claims that a condition suffered by an employee results from an injury arising out of and in the course of employment.

Customer Service: the point of contact where assistance is provided regarding questions or information.

Disability: incapacity due to injury to earn in the same or any other employment the wages which the employee was receiving at the time of the injury.

Emergency: the sudden and unexpected onset of a condition that requires medical care or treatment, including hospital service, that could result in the risk of loss of life or permanent damage to the employee's health if he/she did not receive immediate medical attention.

First Report of Injury (DWC-1): the document an employer is required to complete in the event of an on the job injury of an employee. Commonly referred to as the "Notice of Injury".

Grievance: a written complaint, other than a petition for benefits, filed by the injured worker pursuant to the requirements of the managed care arrangement, expressing dissatisfaction with the insurer's workers' compensation managed care arrangement's refusal to provide medical care or the medical care provided.

Health Care Facility: any hospital licensed under Florida Statutes, Chapter 395 and any health care institute licensed under Florida Statutes, Chapter 400.

Glossary of Terms & Definitions

Health Care Provider: a physician or any recognized practitioner who provides skilled services pursuant to a prescription or under the supervision or direction of a physician and who has been certified by the agency as a health care provider. The term "health care provider" includes a health care facility.

Independent Medical Examination (IME): an objective evaluation of the injured employee's medical condition, including, but not limited to, impairment or work status, performed by a physician or an expert medical advisor at the request of a party, a judge or compensation claims, or the agency to assist in the resolution of a dispute arising under Florida Statutes, Chapter 440.

Independent Medical Examiner: a physician selected by either an employee or carrier to render one or more independent medical examinations in connection with a dispute under Florida Statutes, Chapter 440.

Injury: work injury or death by accident arising out of and in the course of employment, and such diseases or infection as naturally or unavoidably result from such injury. Damage to dentures, eyeglasses, prosthetic devices and artificial limbs may be included in this definition only when the damage is shown to be part of, or in conjunction with, an accident. This damage must specifically occur as the result of an accident in the normal course of employment.

Insurer: an insurance carrier, self-insurance fund, assessable mutual insurer, or individually self-insured employer.

Nurse Case Manager: a nurse specially trained to assist the MCC in evaluating and implementing an approved treatment plan and the employee with any problems or questions that may arise during the treatment of a work-related injury or illness. The Nurse Case Manager also schedules all of the health care needs relating to the work-related injury.

Maximum Medical Improvement (MMI): the date after which further recovery from, or lasting improvement to, an injury or disease can no longer reasonably be anticipated, based upon reasonable medical probability.

Medical Care Coordinator (MCC): a primary care provider within a provider network who is responsible for managing the medical care of an injured worker, including determining other health care providers and health care facilities to which the injured employee will be referred for evaluation or treatment. A medical care coordinator shall be a physician licensed under Chapter 458, an osteopathic physician licensed under chapter 459, a chiropractic physician licensed under chapter 460, or a podiatric physician licensed under chapter 461.

Managed Care Arrangement (MCA): an arrangement under which a provider of health care, a health care facility, a group of providers of health care, a group of providers of health care and health care facilities, an insurer that has an exclusive provider organization approved under s. 627.6472, or a health maintenance organization licensed under Part I of Chapter 641

has entered into a written agreement directly or indirectly with an insurer to provide and to manage appropriate remedial treatment, care, and attendance to injured workers in accordance with Florida Statutes, Chapter 440.13.

Palliative Care: noncurative medical services that mitigate the conditions, effects, or pain of an injury.

Peer Review: an evaluation by two or more physicians licensed under the same authority with the same or similar specialty as the physician under review, for the appropriateness, quality, and cost of health care and health services provided to a patient, based on medically accepted standards.

Permanent Impairment: any anatomic or functional abnormality of loss determined as a percentage of the body as a whole, existing after the date of maximum medical improvement, which results from the injury.

Physician: a physician licensed under Florida Statutes, Chapter 458, an osteopathic physician licensed under Chapter 460, a podiatric physician licensed under Chapter 461, an optometrist licensed under Chapter 463, or a dentist licensed under Chapter 466, each of whom must be certified by the agency as a health care provider.

Primary Care Provider: except in the case of emergency treatment, the initial treating physician and, when appropriate, continuing treating physician, who may be a family practitioner, general practitioner, or internist physician licensed under Chapter 458; a family practitioner, general practitioner, or internist osteopathic physician licensed under chapter 459; a chiropractic physician licensed under chapter 460; a podiatrist licensed under Chapter 461; an optometrist licensed under Chapter 463; or a dentist licensed under Chapter 466.

Provider Network: a comprehensive panel of health care providers and health care facilities, which have contracted directly or indirectly with an insurer to provide appropriate remedial treatment, care, and attendance to injured workers in accordance with Florida Statutes 440.

Reimbursement dispute: any disagreement between a health care provider or health care facility and carrier concerning payment for medical treatment.

Service Area: the agency approved geographic area within which an insurer is authorized to offer a workers' compensation managed care arrangement.

Specialist Provider a physician who is licensed in the State of Florida, including a doctor of dentistry and doctor of optometry and one who has agreed to provide covered services. The MCC will coordinate all medically necessary referrals for specialty care. If an employee with a work-related injury or illness requires additional visits and/or testing, authorization must be obtained by the MCC, MCA Authorizer, or Nurse Case Manager prior to services being rendered.

Glossary of Terms & Definitions

Utilization Review: the evaluation of the appropriateness of both the level and the quality of health care and health services provided to a patient, including, but not limited to, evaluation of the appropriateness of treatment, hospitalization, or office visits based on medically accepted standards. Such evaluation must be accomplished by means of a system that identifies the utilization of medical services based on practice parameters and protocols of treatment as provided for in Florida Statues, Chapter 440.13.

The Physicians Role in Managed Care

Workers' compensation is intended to provide only those medical and disability benefits needed to support the injured employee through the healing and return to work process. The desired outcome is to minimize the disability period and permanent impairment by providing prompt medically necessary services that will restore the injured employee as closely as possible to pre-injury status. It is the responsibility of every authorized health care provider in the workers' compensation program to contribute to this outcome without jeopardizing medical care.

The physician, from the onset of treatment, must reinforce the return to work goal in communication with both the injured employee and the employer. Both parties realize that their long-term interests are best served by maintaining the employment relationship. At the time the physician submits the Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form (Form DWC25), the current work status of the injured employee must be provided to the carrier based on any medical restrictions the physician identifies. The physician should not hesitate to ask for, nor should the employer hesitate to provide, the written job description that specifies the essential functions of the job, as well as the physical and environmental requirements to which the injured worker must return.

Except in an emergency, the physician must obtain authorization from the employer's insurance carrier (or from the employer, if self-insured), in order to render care to an injured employee. Only ***CHOICE Provider Network*** participating providers who have completed the mandatory five (5) hour course or have the appropriate exemption and are certified by the Division of Workers' Compensation as eligible to receive payment under the workers' compensation law may be authorized by the insurance carrier to provide medical services.

Benefit Coverage

Under the Florida workers' compensation law, benefits are determined by the rate of wages an employee receives, the period of disability, and the nature of the injury. There are two categories of benefits an injured worker may receive, medical and indemnity.

Medical includes all necessary remedial treatment, care, and attendance for such period as the injury or process of recovery and return to work may require. This must include medicines, medical supplies, durable medical equipment, and other medically necessary services. Medical care does not require a seven (7) day waiting period. There are no deductibles or co-payments with the exception of when an employee reaches maximum medical improvement (MMI). The employer is responsible for all medical payments related to the compensable injury.

Indemnity benefits are the wage replacement payments an injured worker receives when unable to work. Indemnity benefits are subject to a seven (7) day waiting period. The rate of payment is based upon the classification of disability as well as the employee's base salary prior to the injury.

In the case that an injured worker does not miss time from work, but is receiving medical treatment, the term "medical only" is used. When the injured worker is unable to work for seven (7) days, the claim is termed as a "lost time claim".

Workers' Compensation Coverage

Scope of Coverage – The Florida Workers' Compensation law provides coverage under a WCMCA for health care service for employees with work-related injuries, occupational diseases, or illnesses arising out of, and in the course of employment. There are no deductibles, coinsurance percentages, or aggregate limits. However, employees who do not use participating providers may be required to pay all or a portion of their medical expenses.

Co-Payment – Should an employee with a work-related injury or illness reach overall maximum medical improvement and desire further medical treatment, the employee will be responsible for a $10.00 co-payment per visit. The co-payment shall not apply when emergency care is provided to the employee with a work-related injury or illness.

Eligibility for Benefits – All employees with a work-related injury or illness are entitled to necessary medical care. In the event the employee loses time from work because of the related injury or illness, the employee may receive compensation for time missed in excess of seven days. The employee receives no compensation for the first seven days unless more than twenty-one days are missed.

Impairment Income Benefits – Entitlement is based upon the impairment rating established by the provider and begins on the day after the employee with a work-related injury or illness reaches maximum medical improvement (MMI) or at the expiration of temporary benefits, whichever occurs first.

Supplemental Benefits – Provides supplemental benefits, to be paid to the employee with a work-related injury or illness, with an impairment rating of 20% or more, who has not returned to work, or has returned to work earning less than 80% of the average weekly wage as a direct result of the employee's impairment, and has attempted to obtain employment.

Some Reasons for Denial – Listed below are examples of, but not limited to, circumstances which may create disputes of payor responsibility:

1. When an injury is occasioned primarily by the intoxication of the employee; by the influence of any drugs, barbiturates, or other stimulants not prescribed by a physician; or by the willful intention of the employee to injure or kill himself, herself, or another.
2. If the injury is caused by the employee's deliberate disregard of safety and/or willful misconduct.
3. If the employee claims to have been injured on the job, but investigation reveals that his/her condition is unrelated to his/her employment.
4. When the accident is not the major contributing cause of the condition symptoms.
5. The accident or injury did not arise out of or in the course of employment.

Disability Classifications

Workers' compensation is paid based on the following four types of disability:

- Temporary Total Disability
- Temporary Partial Disability
- Permanent Partial Disability
- Permanent Total Disability

- **Temporary Total Disability (TTD)**

  A disability that completely prevents an injured worker from returning to work for a limited period of time. Many of the injured workers you will see may initially fall into this classification. Based upon each individual employee, their sustained injury and the type of work performed, a TTD is subject to reclassification as the injured worker's condition improves and changes.

- **Temporary Partial Disability (TPD)**

  An injury or illness, which prevents the worker from performing at full capacity for a temporary period of time. Often a worker is reclassified from TTD as their condition improves. TPD is by definition temporary and considered subject to change.

- **Permanent Partial Disability (PPD)**

  An injured worker is classified as PPD when they have sustained an injury, which is permanent, but allows for the worker to return to work with some loss of function. A loss of a limb, amputation, or inability to have full use of a specific body part would be classified as PPD. As defined in Florida Statutes under Chapter 446, a permanent impairment is determined once the worker has reached maximum medical improvement.

- **Permanent Total Disability (PTD)**

  This classification is the most extreme type of disability and is defined in the Florida Statute as a catastrophic injury, whereby the injured worker is unable to return to work in any capacity.

Coordination of Care Procedures

Employee reports injury or illness to Employer

⇓

Employee is referred to MCC/PCP

⇓

Employer completes the first report of injury and notifies the designated MCA Authorizer or Nurse Case Manager

⇓

MCC/PCP examines employee and renders a diagnosis

⇓

MCC/PCP submits Treatment Plan

⇓

Treatment Plan evaluated by UR Company and coordinated with MCC/PCP

⇓

Referrals to PPO Network Specialist or Hospital when necessary

⇓

Medical treatment monitored for duration of claim by MCA Authorizer or Nurse Case Manager

⇓

Provider forwards billing to TPA (payor)

⇓

Patient Returns to Work

**** In the case of an emergency that requires immediate medical care or treatment that could result in the risk of loss of life or permanent damage to the employee, proceed to the nearest hospital or medical facility.**

Return to Work Coordination

One of the goals of the workers' compensation managed care program is to facilitate timely and appropriate return to work. Effective coordination of return to work efforts requires teamwork from the injured worker, medical provider(s), the employer, and the Nurse Case Managers. Each one of the entities has certain responsibilities or roles to play as a team member. The following table outlines those responsibilities:

The Medical Provider	The Injured Worker
• Identify physical abilities • Provide a release to return to work as soon as appropriate	• Accurately portray the physical demands of the job held at time of accident • Attempt to return to work when released by medical provider
The Nurse Case Manager	**The Employer**
• Communicate physical demands of any jobs available to the medical provider and injured worker • Work with the employer to develop modified duty alternatives that match the limitations of the injured worker • Develop phased in return to work plan when necessary	• Provide an accurate description of the employee's job and any modified duty assignment • Abide by restrictions as stated by medical provider • Develop modified duty alternatives whenever possible

Then injured worker can be returned to work as follows, depending upon the unique circumstances associated with their medical recovery, limitations, and jobs available at the employer.

TYPES OF RELEASE TO RETURN TO WORK

Type of Duty	Description
Full Duty	The injured worker is released with no restrictions. There are no limits to the number of hours worked daily nor the number of days per week the employee can work.
Modified Duty	The injured worker has restrictions and cannot perform their usual job. A job can be modified by changing some of the job functions. Modifications can include physical adjustments to the work site, such as chairs, tables, lazy susans, etc., or how the activity is performed, such as using a different handle on a tool or giving a specific function to a co-worker to perform until the injured worker is able to perform that function again.
Part Time Work	Part time assignments are a form of modified duty. When stamina is an issue for an injured worker, part time duty may be appropriate. Hours can be increased as the employee recovers.

Return to Work Coordination

The Nurse Case Manager is experienced in creating modified duty assignments. When necessary, a Field Case Manager will visit the work site to analyze the employee's job or other jobs that might match their physical abilities. Once the employee's restrictions are known, the Nurse Case Manager can work with the employer to seek appropriate modifications through work aides or modified duty assignments.

IDENTIFYING PHYSICAL ABILITIES

As the medical provider, you indicate what the injured worker is able to do and the duration of specific activities.

The DWC-25 form is to be completed for all injuries. The intent is to obtain current knowledge about the treatment plan, any needed referrals or tests, and the injured worker's physical abilities. The form should be completed after each visit and faxed back to the appropriate Nurse Case Manager. The Nurse Case Manager will use the information to coordinate an appropriate return to work or to transition the injured worker from a modified duty job to a full duty job.

As the provider, you will be asked to determine if the employee is able to work an 8 hour shift or if they are restricted to fewer hours. Additionally, you will be asked to determine the maximum amount of weight that can be safely lifted and the frequency this weight can be lifted and carried. Other physical demands (upper and lower extremities) you will be asked to address include:

- reaching in front of body
- fine finger manipulation
- reaching above shoulders
- using foot controls
- sitting
- bending at knee
- crawling
- standing
- walking
- squatting
- grasping
- bending at waist
- driving
- climbing
- pushing/pulling
- kneeling

Providing Releases to Return to Work

Since workers' compensation pays for both related medical care and lost wages, an important focus of managed care is on timely and appropriate return to work. The old practice of not releasing an employee back to work until they have reached maximum medical improvement is gone. It is now known that the longer the employee is away from work, the less likely it is that they will return to work. Except in cases of permanent total disability, this is a loss for both the worker, whose earnings are reduced, and for the employer who has lost the productivity of a valuable employee.

THE OLD APPROACH TO RETURN TO WORK			THE *NEW* APPROACH TO RETURN TO WORK		
Date of Accident	MMI Date	Return to Work	Date of Accident	Return to Work	MMI Date

Each time you examine the injured worker, CHOICE will expect you to assess

- The ability of the worker
- Any physical restrictions

Record any restrictions on the claims payor's functional capacity form which may also act as a release to return to work form. The physical abilities that are indicated on the form assist the case manager in coordinating a return to work. As the medical provider, it is your responsibility to identify **when** the injured worker is capable of attempting to return to work.

The Nurse Case Manager will work closely with the employer to find suitable employment based upon the abilities and restrictions that you outline. Many employers are flexible when it comes to job responsibilities and return to work. Once you identify any limitations, the Nurse Case Manager and the employer can work together to either modify an existing job to meet the requirements you have outlined, find a job that matches the restrictions, or create a job that will allow the employee to return to work.

Often, the Nurse Case Manager will provide you with a copy of a job description that outlines the physical demands of a potential job. When you receive a job description you should compare the physical demands listed and your opinion regarding the injured worker's ability to perform those functions. If you do not feel they can perform all the physical demands, indicate clearly what should be changed in order to allow the injured worker to return to work. Do not rule out the entire job if there are only a few exceptions. If you let the nurse case manager know about your concerns, they can often discuss with the employer and modify the position to meet your restrictions.

It is good practice to discuss the restrictions and release with the injured worker. This provides the opportunity for the injured worker to address any concerns that they may have and allows you to explain what your recommendations are based upon. Sometimes the injured worker may indicate that they are not ready to return to work despite your opinion.

Providing Releases to Return to Work

You will have to assess each case individually, but if you feel it is appropriate for the employee to **try** working, let them know that your recommendation will stand. If their medical condition changes, you will reassess this decision.

Successful return to work is to everyone's advantage. An unsuccessful attempt undermines the confidence of the injured worker and may cause an exacerbation of the condition. If you have doubts about a full duty release to return to work or an 8 hour day, don't hesitate to phase in the return to work. The Nurse Case Manager will work with you, the employee and the employer to develop a strategy to get the worker back on a regular schedule as soon as their condition allows. Remember, recovery at work is our objective whenever feasible.

Provider Procedures for Treatment

- After a worker is injured, his/her employer will refer the worker to a Medical Care Coordinator (MCC) or Primary Care Provider (PCP). The designated MCA Authorizer is available to assist with identifying a provider. In some instances, an employee has been seen at an emergency room, or has been discharged from the hospital, and needs continued care. The employee will be referred through the MCA Authorizer or Nurse Case Manager. The treating physician (MCC/PCP) will be contacted prior to the referral to assure that he/she is aware of the case. The MCA Authorizer or Nurse Case Manager will arrange for the transfer of medical records.

- The injured worker will identify and see a ***CHOICE Provider Network*** MCC/PCP for health treatment.

- The treating physician should obtain authorization from the MCA Authorizer. Refer to the ***"CHOICE Provider Network Client Listing"*** or injured employee authorized to treat form for authorization to evaluate the patient.

- Once the worker has been evaluated and has received initial treatment, the treating physician is required to complete the "Physicians Assessment and Recommendation" form and fax or mail the form, within one business day, to the MCA Authorizer.

- The MCA Authorizer will phone the treating physician to discuss the plan of treatment and return to work goals within one (1) business day of receipt of form. If there are any questions concerning the proposed plan of treatment, the MCA Authorizer's Physician Advisor will contact the treating physician to discuss the case.

- The treating physician will initiate the plan of treatment and discuss return to work goals with the injured worker. If a referral is indicated, the treating physician will contact the MCA Authorizer or Nurse Case Manager to discuss the referral recommendation and plan of treatment.

- All referrals for specialist consultation and ancillary health services must be authorized and coordinated with the primary treating physician (MCC/PCP) and the MCA Authorizer or Nurse Case Manager. The treating physician will provide the patient with a copy of their medical records with instructions to take all documents to the specialist at the time of the appointment.

- The MCA Authorizer will review the referral request, and, if approved, will notify the specialist of authorization to render services as defined. The MCA Authorizer or Nurse Case Manager will call the injured worker with instructions regarding appointment(s).

Quality Assurance Program

Our goal at ***CHOICE Provider Network*** is to ensure that the injured worker receives prompt and efficient care to facilitate an earlier return to work. It is our aim to deliver high quality and appropriate medical care to an injured worker, restoring them to a positive state of health and enabling them to return to his/her previous occupation on part-time and/or modified duties as quickly as possible without sacrificing the quality of care.

Quality improvement is essential to the success of the WCMCA. Activities are developed and coordinated to ensure an ongoing program designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care and to identify and resolve problems using prevailing professional standards of care.

Nationally and regionally accepted treatment guidelines are used, including health service practice parameters adopted by AHCA (Agency for Health Care Administration), which apply to compensable diagnoses as tools for the quality measurement of treatment proposed or rendered by our health care providers. In addition, quality improvement (QI) indicators are developed based on the Joint Commission on Accreditation of Healthcare Organization, (JCAHO) and National Committee for Quality Assurance (NCQA). The outcomes are evaluated through quarterly and annual monitoring of activities.

Workers' compensation is intended to provide prompt, appropriate medical and disability benefits needed to support the injured employee through his or her healing and return to work process. Our desired outcome is to minimize the disability period and provide a managed care solution, which shares in the responsibility to contribute to this outcome without jeopardizing medical care. We must all work together to reinforce the return to work goal through communication between the provider, the injured employee, and the employer. Our long-term interests are best served through this coordinated effort.

Medical Records Requirements

In order to comply with Florida State Statutes Section 440.134, the provider will submit the following information:

- DWC-25 Uniform Medical Treatment/Status Reporting Form (required by the Division of Workers' Compensation)

A complete report must be supplied to the carrier within three (3) days of initial treatment, then every thirty (30) days thereafter. Failure to provide this information may result in fines by the Division of Workers' Compensation and may result in non-payment of medical services.

The MCA Authorizer or Nurse Case Manager assigned to the employee with a work-related injury or illness will monitor medical information and will communicate with providers who do not comply with the guidelines. The provider shall maintain records for a period of time not less than seven (7) years from the date of the last treatment as required by law and as stated in the participating provider agreement.

Documentation of Medical Necessity – when specifically requested, the provider must substantiate the medical necessity of services performed. When it is necessary to substantiate the medical necessity of services beyond the information contained in the medical record, the prescribing provider must submit the supporting documentation in writing.

Practice Parameters – the carrier must evaluate the appropriateness and utilization of medical services provided to injured workers in accordance with the medical practice parameters developed by AHCA for use with the Workers' Compensation Program. A copy of the currently endorsed practice parameters may be obtained by contacting AHCA through their Hot Line number at (888) 419-3456.

Accessibility & Available Service Standards

The following standards are applicable to all ***CHOICE Provider Network*** participating providers:

Emergency Care	Immediate
Initial Injury	Same Day
Urgent Care	Within 24 Hours
Waiting Time-Scheduled Appointments	Within 30 Minutes
Specialist Appointment	Within 5 Working Days
Lab Procedures	Within 72 Hours
Radiology Procedures	Within 72 Hours
Physical Therapy	Within 5 Days
Travel Time to MCC or Acute Care	Max 30 Minutes
Travel Time to Specialist or Ancillary	Max 60 Minutes
MCA Authorizer Response Time	Within 24 Hours
Network Provider Services Response	Within 24 Hours

Claim Submission Procedures

When services have been provided, a bill must be submitted with all supporting documentation and reports to receive payment. Refer to the injured employee authorized to treat form or the ***CHOICE Provider Network Client Listing*** for claim submission addresses. All claims are to be sent directly to the claims payor, unless noted differently for a specific employer.

Claims for solo practitioners, group practice providers, clinics, and hospital-owned clinics, must be submitted on an HCFA-1500 form. Hospitals must submit claims on a UB-92 form.

Only medical expenses for work-related injuries or illness are to be billed to the workers' compensation claims payor. The following information must be included:

- Name, Age, Sex, Address, and Social Security Number of the employee
- Employer's Name and Address
- ICD-9 Diagnostic Code(s)
- CPT-4 Procedure Code
- Your Normal Charges by CPT-4 Code
- Name, Address, Signature, Medical Licence Number and Tax ID of physician providing service
- Date(s) of service
- Procedure(s) description

Submit all claims with full fee amount and the appropriate codes and information. Do not discount fees prior to claim submission. In order for claims to receive prompt remittance, each claim should be checked for completeness and accuracy prior to submission. Acceptance of contractual amounts as payment in full is required to comply with state law.

When the remittance payment is received, there will be an Explanation of Benefits form (EOB) accompanying the check. It will include the following:

- Name and SS Number of the employee
- Date(s) of service
- Total charges submitted
- Allowed amount
- Non-covered service
- Amount paid

If there are any questions or concerns regarding the reimbursement of a medical bill, contact the payor at the number indicated on the EOB or refer to the ***CHOICE Provider Network Client Listing.***

Grievance Procedures

The purpose of the Grievance Process is to provide a readily accessible mechanism for resolving complaints and written grievances by injured employees and providers. The grievance procedure may also be utilized for the resolution of disputes arising between a health care provider and employer regarding reimbursements and utilization review. The grievance procedure will be utilized to rapidly resolve disputes involving the injured employee, health care provider, employer, or insurer. The procedure will be aimed toward mutual agreement, and may include arbitration.

Grievance Coordinator: The Grievance Coordinator will assist with the implementation of the grievance procedure. The Grievance Coordinator will document the nature of the concern and provide the complainant with a description of the grievance process. The Grievance Coordinator will insure that the complaint is documented and directed to the proper problem solving authority without undue delay. Emergency situations will be brought to the immediate attention of the senior management or proper problem solving authority. ***The Grievance Coordinator can be reached at (813) 282-9801 or (888) 823-5377.***

INITIATION OF A REQUEST FOR SERVICE, COMPLAINT OR GRIEVANCE

Request for Services:

Employees who wish to make a request for service shall do so by contacting the nurse case manager or adjuster assigned to their claim.

- The case manager or adjuster will evaluate the request for service and will notify the employee of the decision to grant the request, to deny it, or to request additional information within seven (7) calendar days.

- When a request is denied, the case manager or adjuster assigned to the claim shall notify the employee in writing of the denial and advise the employee of their right to file a grievance. The employee will also be provided with a copy of the required grievance form (AHCA form no. 3160-0019).

- If the request for service is not responded to within seven (7) calendar days of receipt, the injured employee may make a complaint or file a written grievance.

Complaint:

Employees dissatisfied with their medical care may contact the Nurse Case Manager, Adjuster or Grievance Coordinator. A complaint must include information adequate for investigation and resolution. In cases of reimbursement dispute, requests should include the reason for the dispute and the reason that charges are valid.

- The Nurse Case Manager, Adjuster or Grievance Coordinator will address the complaint in a timely manner in order to expedite the resolution of issues of providers and injured employees. Complaints will be investigated and

resolved within ten (10) calendar days of receipt unless the parties and the insurer or delegated entity mutually agree to an extension. The ten (10) days shall commence upon receipt of a personal or telephone contact by the insurer or delegated entity from the injured employee, provider, designated representative, the Agency or Division.

- A complaint that is denied or remains unresolved after ten (10) calendar days shall result in notification to the affected parties in writing of the reason for denial and their right to file a grievance. The written notification shall include the name, title, address and telephone number of the Grievance Coordinator. In addition the employee will be notified of their right to contact the Division's Employee Assistance Office at the Department of Insurance, Division of Workers' Compensation for additional information on rights and responsibilities and the dispute resolution process under Chapter 440, F.S. and related administrative rules.

Written Grievance

A grievance is defined as a written complaint, other than a petition for benefits, filed by an injured workers pursuant to the requirements of the managed care arrangement, expressing dissatisfaction with the insurer's workers' compensation managed care arrangement's refusal to provide medical care or the medical care provided. Initial requests for medical services, second opinions, or changes in providers are not considered grievances.

- The grievance procedure shall commence upon receipts of a signed grievance form (AHCA Form no. 3160-0019) by the insurer or delegated entity, from the injured employee, provider or their designated representative. A grievance may be submitted or withdrawn at any time. The injured employee or provider is not required to make a complaint prior to filing a written grievance.

- The employer shall be notified when a grievance is filed.

- A meeting between the insurer or delegated entity and the injured employee or provider will be provided during the written grievance process if requested by the injured employee or provider. The meeting will be offered at a location convenient to the injured employee or provider within the service area.

- Arbitration will be provided, but is not required under the grievance procedure. The injured employee may still file a request for assistance with the Division of Worker's Compensation relating to non-medical issues.

- Upon completion of the grievance procedure, the Grievance Coordinator shall provider written notice to the employee of their right to file a petition for benefits with the Division of Worker's Compensation.

- A physician other than the injured employee's primary care physician shall be involved in reviewing medically related grievances.

GRIEVANCE PROCESSING TIME FRAME

The Grievance Coordinator will investigate the grievance and notify the employee of a final decision in writing within fourteen (14) calendar days after the grievance has been received. Urgent grievances will be promptly reviewed and a determination shall be rendered and communicated to the injured employee within three (3) days from receipt. If the grievance involves collection of information outside the service area, the Grievance Coordinator will have an additional fourteen (14) calendar days to respond to the grievance. The employee and employer shall be notified in writing of the resolution of the grievance, and the reasons therefore within seven (7) days of the final determination. If the grievance is arbitrated pursuant to Florida Workers' Compensation Law 440.134, then additional time, not to exceed two-hundred and ten (210) calendar days from receipt of the written request for arbitration from the employee, is permitted. The Grievance Coordinator will maintain a record of each formal grievance. If the determination is not in favor of the aggrieved party, the Grievance Coordinator shall notify the aggrieved party that the grievance is being forwarded to the grievance committee for further consideration unless withdrawn in writing by the employee or provider. The grievance committee shall render a determination within thirty (30) calendar days or receipt unless the grieving party and the committee mutually agree in writing to an extension.

A detailed record of the filed complaint and grievance will be maintained by the managed care arrangement. The record will include the following:

- A complete description of the grievance
- The employee's name and address
- The provider's name and address
- The managed care arrangement's name and address
- A complete description of the findings, conclusions, and disposition of the grievance
- A description of the current level at which the grievance has been processed and the levels remaining before completion of the entire grievance process.

An annual report of all grievances filed by employees and providers shall be submitted to the Agency for Health Care Administration, Division of Health Quality Assurance, 2727 Mahan Drive, Tallahassee, Florida 32308, no later than March 31. The report shall list the number, nature, and resolution of all formal employee and provider grievances.

Florida Workers' Compensation Managed Care Arrangement
FORMAL GRIEVANCE FORM

An Injured Worker or Health Care Provider shall use this form to request a formal review about dissatisfaction with medical care issues provided by or on behalf of a Workers' Compensation Managed Care Arrangement..

This Grievance is Filed by:
___Provider ___Injured Worker or a Designated Representative: __ Family Member __ Attorney __ Other
Date of Injury_____

INJURED WORKER'S/ PROVIDER'S NAME: _____
Social Security Number _____
Address: _____
Home Telephone: _____ Work/Alternate Phone: _____

Contact if other than injured worker or provider_____ Telephone #_____

PRIMARY CARE/TREATING PHYSICIAN: _____
Address: _____
Office Telephone: _____

If the space provided below is inadequate for you to fully explain your concern or the action you desire, continue your statement on a sheet of plain paper. Please be sure your name and social security number appear on each page of any attachment.

Why is this grievance being filed? (Nature of the problem): _____

What Action Would You Like to See Taken?

Have you received any information regarding your rights and responsibilities under WC Managed Care?Yes No

Florida Workers' Compensation Managed Care Arrangement
FORMAL GRIEVANCE FORM

INTENT: The grievance procedure is intended to be self-executing and easy to use. An injured worker may call the grievance coordinator directly without completing this form. The grievance coordinator may complete the form for the injured worker. A review regarding the requested medical care will begin immediately, and a decision made within 44 days of receipt unless additional information is required from outside the service area. The review period may be extended by mutual agreement between the injured worker and the grievance coordinator, with notice provided to all other participating parties.

The injured worker's participation in the grievance process is important to the resolution of medical issues. Individuals reviewing the grievance may need to speak directly with and receive input from the injured worker. If the injured worker is unable to participate actively in the grievance process, a patient advocate may participate on behalf of the injured worker.

If the injured worker, employer, or carrier is dissatisfied with the final decision of the grievance committee, the dissatisfied party has the right to file a petition for Benefits with the Florida Division of Workers' Compensation.

Any person who, knowingly and with intent to injure, defraud, or deceive any employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Form Completed by: _____ _____
Injured Worker/ Provider/ Other — Date Form Completed/Signed

_____ _____
Signature of Grievance Coordinator — Date Grievance Coordinator Signed

MAIL TO: Anne Creighton, Grievance Coordinator
Genex Services, LLC
1408 N. Westshore Blvd., Suite 700
Tampa, FL 33607-4517
(888) 823-5377

Provider Services

The ***CHOICE Provider Network*** Services staff is prepared to assist in ensuring the satisfaction of participants in the WCMCA program. We feel very strongly that a top quality network is successful and enhanced through ongoing education, communication, and long-term relationships with our community based providers. Our Provider Services team members are available to answer any questions concerning participation in the managed care arrangement, and we welcome any comments, suggestions, and communication.

In addition to the Provider Manual, a team member of the Provider Services Department is available for training to help providers and staff understand participation in the ***CHOICE Provider Network*** MCA.

The Provider Services Department can be contacted at (888) 823-5377.

Please notify Provider Services of any changes in the following:

- Tax ID number
- Office address
- Billing information
- Telephone or FAX numbers
- Group participation status
- Resignation of a provider (e.g. retirement, death, out of state move)
- Termination of Provider Agreement
- Addition of a provider
- Professional liability coverage

Provider Credentialing

CHOICE Provider Network has adapted criteria that meet national standards in accordance with state and federal licensing regulations. In addition to initial credentialing, providers will be recredentialed every two years.

Provider Education

Florida Statutes previously required workers' compensation physicians to complete a minimum of five (5) hours of study that included the subject areas of cost containment, utilization control, ergonomics, and the practice patterns adopted by the Division governing the physician's field of practice. The statute still recognizes the previous certification, however, the State has shifted the responsibility of new and continued certification to the managed care arrangement.

In order to satisfy the new requirements, *CHOICE* provides its' physicians with this education manual. *CHOICE* is required to keep a signed affidavit on file for each new physician stating that the manual has been read and understood and this information is communicated to the State so that they can update their list of workers' compensation certified physicians. Additionally, *CHOICE* also provides periodic newsletters to it's participating physicians ..

Who To Call

CHOICE Provider Network (813) 282-9801 or (888) 823-5377
FAX (866) 641-1584
Network Provider Questions – Procedural Questions – Network Services

Reviewing Company
Authorization for Services
Refer to ***CHOICE*** **Provider Network** Client Listing

Third Party Administrator (TPA)
Refer to ***CHOICE*** **Provider Network** Client Listing
Questions regarding specific claims
Claim submission procedures

PATIENT IDENTIFICATION

- Injured worker must present an authorized form or verbal MCA authorization to obtain coverage
- Employer Group will issue a form to the injured worker
- Forms will identify the MCA Authorizer
- Employee is referred to a *CHOICE* Provider Network MCC or PCP

MCC/PCP PROVIDER TREATMENT PROCEDURES

- MCC/PCP will follow the directions on the patient's treatment form for authorization to Evaluate the patient
- MCC/PCP must complete a "Physician's Assessment & Recommendation" form
- MCC/PCP must fax or mail "P A & R" form to MCA Authorizer within one (1) business day
- Refer to patient's treatment form or ***CHOICE*** **Provider Network** Client Listing for specified MCA Authorizer

REVIEWING COMPANY TREATMENT PROCEDURES

- MCA Authorizer will contact treating physician (MCC/PCP) to discuss plan of treatment
- MCC/PCP will initiate authorized plan of treatment
- MCC/PCP will initiate return to work goals with the injured worker
- MCA Authorizer will provide ongoing contact with treating physician to discuss progress

SPECIALIST REFERRALS

Non-Urgent Care: (within 72 hours)

- MCC/PCP will fax or mail a referral to MCA Authorizer
- MCA Authorizer will notify MCC/PCP of approval or non-approval
- MCC/PCP will provide medical records with instructions to the Specialist
- MCA Authorizer will notify ***CHOICE*** **Provider Network** of approval
- MCA Authorizer will notify patient of "Non-Approved Referral" and alternate treatment plans

Urgent Care (within 24 hours)

- MCC/PCP will refer patient to a network Specialist
- MCC/PCP must notify the MCA Authorizer specified on employee's treatment form or Client Listing
- Specialist provider must be able to see the patient within 24 hours
- Specialist provider must return completed forms to MCC/PCP within three (3) days of visit
- MCC/PCP will contact MCA Authorizer to discuss recommendations and treatment plan

In the event of an emergency with threat of loss of life or limb, patient should proceed to nearest medical service facility, then notify Employer and MCA Authorizer within 24 hours.

MMI – MAXIMUM MEDICAL IMPROVEMENT

The provider identifies when the injured worker reaches maximum medical improvement. Maximum medical improvement is reached when further recovery from, or lasting improvement to, an injury or disease can no longer reasonably be anticipated based upon reasonable medical probability. If any permanent impairment exists, it should be documented immediately.

Once an injured worker has reached maximum medical improvement, they become responsible for a $10 per visit co-payment for ongoing medical treatment. This co-payment applies only to dates of accident on or after January 1, 1994 and does not apply to emergency care. The co-payment is to be collected by the health care provider and will be deducted from the allowable fee billed to the carrier by the provider.

Permanent Impairment

After maximum medical improvement occurs or six (6) weeks before the expiration of temporary benefits, whichever occurs earlier, it is necessary to assess if the injured worker has a permanent impairment. Permanent impairment is defined in the statute as any anatomic (physiologic) or functional abnormality or loss after maximum medical improvement has been achieved which the physician considers stable or non-progressive at the time the evaluation is made. This is a purely medical condition. Permanent disability means that the actual or presumed ability to engage in gainful activity is reduced or absent because of an impairment which may or may not be combined with other factors such as age, sex, education, or socioeconomic status.

Compensation is not payable for the mental, psychological, or emotional injury arising out of depression from being out of work.

If a doctor other than the employee's treating doctor performs the certification and evaluation, the certification and evaluation must be submitted to the treating doctor, and the treating doctor must indicate agreement or disagreement with the certification and evaluation. The certifying doctor issues a written report to the division, the employee and the claims payor certifying that maximum medical improvement has been reached, stating the impairment rating, and providing any other information required by the division.

The following impairment rating guides are to be used for the associated dates of accident:
Date of Accident Prior to 7/90.....AMA Guides
Date of Accident beginning 6/21/93.....Florida Impairment Rating Guide (FIRG)

Contact: Florida Workers' Compensation Institute (850) 425-8156 or AHCA (Agency for Healthcare Administration) Hotline (888) 419-3456

CLAIM SUBMISSION

Claims must be submitted on a HCFA 1500 form that contains the appropriate CPT-4 and ICD-9 codes. Refer to employees authorized to treat form or ***CHOICE*** **Provider Network** Client Listing for information regarding where to submit claims. Do not discount fees prior to claim submission. Do not submit claims directly to Genex / ***CHOICE*** **Provider Network.**

Note: Check claims for completeness and accuracy; this will expedite the processing. Bill only for medical expenses for work related injuries or illness to the Workers' Compensation claim payor.

CHOICE **Provider Network adheres to Florida Statutes, Chapter 440, pertaining to Florida Workers' Compensation Laws effective January 1, 1997.**

CHOICE **Provider Network, A Division of Genex Services, LLC**
1408 N. Westshore Blvd., Ste. 700 Tampa, FL 33607

Employee Rights and Responsibilities

Injured workers (employees) that are covered by ***CHOICE Provider Network*** policies with their employers assume certain rights and responsibilities when receiving services through Managed Care Arrangement.

Case Managers, Claims Adjusters, and employers inform injured workers of their rights and responsibilities.

The following two pages contain the rights and responsibilities of injured workers who receive medical, vocational, and rehabilitation services through ***CHOICE Provider Network*** providers.

Employee Responsibilities

1. To understand how the Managed Care Arrangement works by reading all materials and letters.

2. To select and seek all non-emergency care by appointment through the Medical Care Coordinator (MCC) or Primary Care Physician (PCP), to obtain referrals from your MCC/PCP, and to cooperate with Case Managers and Claims Adjusters who arrange for your care and treatment.

3. To be on time for appointments.

4. To notify the physician's office well in advance if you need to cancel or reschedule an appointment. Failure to do so may result in increased financial liability with respect to Independent Medical Evaluations (IME).

5. To be respectful and not disruptive to the rights, property, and environment of all providers, employees, and other patients.

6. To understand and follow medical advice concerning your treatment, and to ask questions if you do not understand or if you need an explanation of your treatment and return to work plan.

7. To understand the medications prescribed to you, what they are, what they are for, and how to take them properly.

8. To provide accurate and complete medical information, work history, and work injury to Case Manager/Adjuster and Providers as may be required to prepare treatment and return to work plans.

9. To pay all required co-payments at the time services are provided, once the Maximum Medical Improvement (MMI) is reached.

10. To be certain your current Medical Care Coordinator (MCC) or Primary Care Physician (PCP) has copies of all previous medical records.

11. To notify your employer or Case Manager/Adjuster within twenty-four (24) hours if you are hospitalized or receive emergency room care while under treatment.

Employee Rights

1. To be provided with information about coverage and services when under a Managed Care Arrangement.

2. To receive considerate, respectful care, and to be treated with human dignity by MCA affiliated providers.

3. To know the names and titles of all physicians and other health professionals involved in your medical treatment.

4. To understand your medical condition, health status, return to work status, and the recommended course of treatment and alternatives that exist, as well as their risks.

5. To participate actively in decisions regarding your medical care.

6. To be informed of continuing health care requirements following discharge from the hospital.

7. To refuse treatment, providing you choose to accept responsibility for and the consequences of such a decision.

8. To refuse to participate in any medical research projects.

9. To have any and all complaints forwarded to the Medical Department, and to receive an appropriate and timely response.

10. To have access to your medical records, and to have the privacy and confidentiality of these records maintained.

11. To complete an advance directive.

12. To make suggestions for improving the Managed Care Arrangement.

13. To request recommendations of unfavorable medical or administrative decisions by following the established complaint and grievance procedures.

14. To have all the above rights apply to the person having legal authority to make decisions regarding your health care.

15. To have ***CHOICE Provider Network*** personnel observe your rights.

16. To exercise your rights without regard to sex, race, ethnic, economic, educational, or religious background.

Practice Parameters (Overview)

1. Introduction

The *Florida Health Care and Insurance Reform Act of* 1993 (§440.13(15), *Fla. Stat.)* directed the Agency for Health Care Administration (AHCA) to develop scientifically sound practice parameters for medical procedures relevant to workers' compensation claimants for treatment of the 10 top procedures associated with workers' compensation injuries including the remedial treatment of lower-back injuries. In response, AHCA convened a workgroup of more than two dozen medical specialists to develop guidelines for neuro-musculo-skeletal conditions. The activities of the workgroup are described below in more detail. Those workers' compensation guidelines which have been endorsed by the agency and those which are to be developed are listed below. For additional information, please contact Dennis Halfhill at (904)921-5505.

Endorsed on October 6, 1995 under the authority of section 408.02, F.S., and section 440.13(15), F.S.

NUMBER	GUIDE	GUIDELINE	ORDER FROM:
4		UNIVERSE OF FLORIDA PATIENTS WITH LOW BACK PAIN OR INJURY; 41 pages; State of Florida, Agency for Health Care Administration (AHCA); October 6, 1995.	Agency for Health Care Admin. (AHCA) Medical Guidelines Clearinghouse *Please see Page* 2
5		UNIVERSE OF FLORIDA PATIENTS WITH NECK PAIN OR INJURY; pages; State of Florida, Agency for Health Care Administration (AHCA); not yet completed.	Agency for Health Care Admin. (AHCA) *Please see Page* 2

Under development as of May 1997 under the authority of section 408.02, F.S., and section 440.13(15), F.S.

6		UNIVERSE OF FLORIDA PATIENTS WITH SHOULDER PAIN OR INJURY; pages; State of Florida, Agency for Health Care Administration (AHCA); not yet completed.	
7		UNIVERSE OF FLORIDA P A TTENTS WITH KNEE PAIN OR INJURY; pages; State of Florida, Agency for Health Care Administration (AHCA); not yet completed.	"
8		UNIVERSE OF FLORIDA PATIENTS WITH FOOT AND ANKLE PAIN OR INJURY; pages; State of Florida, Agency for Health Care Administration (AHCA); not yet completed.	"
9		UNIVERSE OF FLORIDA PATIENTS WITH WRIST AND HAND PAIN OR INJURY; pages; State of Florida, Agency for Health Care Administration (AHCA); not yet completed.	"

LOW BACK PAIN

IA. Background

Low back injuries have been the first or second most common lost-time work injury for Florida employers since 1985 (DWC 1996). This study examines the period October 1993 through September 1994. During this 12-month period, there were 34,563 new work-related back injuries reported by Florida employers. Nearly 42% of the injuries resulted in more than a 7-day absence from work.

Injuries to the low back are not only commonplace, they are also expensive to diagnose and treat, often requiring multiple procedures to restore the employee to good health. There were nearly 589,000 medical procedures associated with the low back injuries under study. More than 10% of these injuries required 45 or more separate medical procedures.

The annual cost of medical care for low back injuries is estimated to exceed $24 billion across the U.S. (Liu and Byrne, 1995). When work loss and disability payments are included, the estimate for total annual costs exceeds $50 billion (Taylor, *et. al.,* 1994). Our analysis of workers' compensation (WC) data examines *new* cases of low back injury only. The average direct medical cost paid by WC insurance for these injuries was $715.40. This does not include costs for treatment of body parts other than the back when an injury affects multiple body parts. It also does not include costs for ongoing treatment of chronic injuries that occurred before the study period. Further, direct medical costs are only one portion of the economic costs associated with low back injuries. Indemnity payments for lost-work injuries typically exceed medical costs (Abenheim *et at.,* 1995; Webster and Snook, 1994). Total economic costs are therefore considerably higher.

Despite the frequency and cost of low back injuries, many studies show wide variation in treatment patterns. Taylor *et al.* (1994) examined the U.S. National Hospital Discharge Survey from 1988 to 1990. They found that rates of back surgery were 50% higher in the South than in the West and non-surgical hospitalizations were nearly twice as frequent. These regional disparities remained even after controlling for sociodemographic characteristics like age and the prevalence of back problems. Other studies show important variations in the use of diagnostic and therapeutic services (Hart *et al.,* 1995; Carey *et al.,* 1995; Schroth *et at.,* 1992). This variation may be explained, in part, by evidence that many therapeutic approaches currently in use offer limited effectiveness in recovery from a low back injury. Lancourt and Kettlehut (1992) show that non-clinical factors, such as personal history, family factors, employment, and general stress can better predict return to work than clinical findings.

The wide variation in diagnostic and therapeutic approaches suggests that the treatment of low back pain is an area suitable for the development and implementation of a practice guideline. Practice guidelines are strategies for patient management, developed on the best scientific evidence available. They assist physicians and other health care professionals to optimize their diagnostic and treatment decisions. The use of a guideline can result in greater consistency in diagnostic and therapeutic treatment as well as reductions in the use of procedures with little or no proven benefit. This should reduce costs and reduce the compliance burden on patients

without having a detrimental effect on clinical or health outcomes. Practice guidelines are not mandatory protocols and they are not reimbursement rules.

The guideline begins with an evaluation by a physician or specialist, including medical history and physical examination. Certain diagnoses are considered exclusionary and immediate referral to a neuro-musculo-skeletal specialist is warranted. Certain red flag conditions also allow immediate lumbar X-rays under the guideline. In the absence of exclusionary diagnoses and red flag conditions, treatment options during the first four weeks favor conservative treatment including: activity modification, limited bed rest, self-exercise, medication, self-applied heat/ice, osteopathic/chiropractic manipulation, physical therapy, and occupational therapy according to specified standards. If the patient's condition is not resolved but is improving, the guideline permits an additional two weeks of conservative treatment. If the condition is unimproved or worsened after four weeks, referral to a neuro-musculo-skeletal specialist is recommended for additional diagnostic and therapeutic interventions.

Generally, the guideline attempts to restrict the use of procedures to situations where they are proven effective. It entirely rules out the use of a number of procedures for treatment of low back injuries. It also specifies the circumstances appropriate for the application of other diagnostic and therapeutic procedures based upon the diagnosis and the amount of time that has passed following the injury. **Figure 1** provides additional detail on the recommended course of treatment during the initial four weeks following a low back injury.

Section §440.13(15) *Fla. Stat.*, the *Florida Workers' Compensation Reform Act of* 1993, mandates that the AHCA low back guideline be used by insurance carriers and the Florida Department of Labor and Employment Security, Division of Workers' Compensation (DWC) in evaluating the appropriateness and over utilization of medical services provided to injured employees. Over 25,000 copies of the guideline were produced in 1996. It was distributed free of charge to more than 16,000 health care providers, insurance carriers, and employers.

Following the development of the guideline, AHCA and DWC initiated a multi-year evaluation project to assess its impact on treatment patterns, costs, and outcomes in the workers' compensation system. The first phase of the evaluation is a pre-guideline baseline study of 1994 low back injuries. This report summarizes the results of the baseline study. Using information from the DWC Medical Claims File, we collected information on all medical and rehabilitative services provided to workers experiencing new low back injuries during the baseline period. The study addresses questions relating to the frequency and type of injury, use of specific diagnostic and therapeutic procedures, and costs of treatment. The use of a pre-guideline baseline will enable researchers to study changes in relevant behaviors and outcomes following the introduction and widespread use of the guideline in 1996.

The study also identifies specific areas where prevailing medical practice during the baseline period differed from the recommended practices reflected in the low back guideline. We have identified eleven specific areas into which we categorize procedures. The areas include: medical office visits, lumbar X-rays, significant imaging (MRI, CT scan, etc.), other imaging, spinal manipulation, physical/occupational therapeutic exercise, physical/occupational – passive

modalities, rehabilitative therapy, surgery, injections, and electrophysiologic testing. We examine each procedure in these areas to determine if it was justified according to the guideline. We then compute the amount spent for procedures outside the guideline recommendations (based on the actual amount reimbursed) in each area. These costs represent the maximum savings that would have been realized had the guideline been in use during the baseline period. This gives a sense of the economic impact that the guideline will have as its use becomes widespread. While these areas do not cover the universe of procedures encompassed by the guideline, they do capture more than 86% of the diagnostic and therapeutic procedures received by the study population.

We have attempted to be conservative in defining procedures as outside the guideline so as to err on the side of under counting them rather then over counting them. We were equally conservative in estimating medical costs. Our preference was to state minimum savings with as much accuracy as possible rather than make debatable assumptions and risk over-estimating the potential cost savings. In some cases, ranges are presented where the data do not permit exact estimates. In these cases, the true figures lie between the bounds but cannot be determined with more precision without making assumptions that go beyond the available statistical evidence.

In addition to studying the use of procedures outside the guideline, we also consider situations where the guideline recommends immediate interventions. The guideline identifies certain red-flag diagnoses for which immediate lumbar X-ray should be considered. It also specifies a set of exclusionary diagnoses which require immediate referral to a neuro-musculo-skeletal specialist as defined in the guideline.

While we cannot code every red-flag or exclusionary diagnosis, we do test several red-flag conditions including: fractures, spinal cord injuries, unexplained weight loss, unexplained fever, immunosuppression, cauda equina syndrome, degenerative bone/joint disease, and age over 70. Each red-flag condition serves as an indicator that an immediate lumbar X-ray should be considered. The decision to X-ray or not is made by the physician based upon the overall condition of the patient. While the data do not permit an evaluation of these decisions, we do report the frequency of the red-flag conditions and the frequency of lumbar X-rays within one week of injury. These baseline figures will be especially important as incentives change following the shift of workers' compensation to mandatory managed care during 1997. We also do not have data on physician specialty so it is not possible to test for appropriate specialty care referrals for exclusionary diagnoses. We do, however, acknowledge the importance of this issue for the quality of care in these cases.

One additional goal of the baseline study is to assist guideline developers in understanding how various procedures have been used historically and what situations are associated with the use of unjustified procedures. This information may be useful during the periodic guideline review and revision process. The guideline is not a fixed protocol. At best it identifies typical courses of treatment appropriate for most patients. By identifying areas where practitioners have seen fit to depart from the guideline recommendations, this study may help make future versions more sensitive to clinical subtleties.

By focusing on new injuries and the early months of treatment following an injury, this study does not consider patients with chronic back pain. While the percentage of cases that require treatment beyond three months is small, the costs for treating them can be large. This study also does not consider acute episodes of back pain stemming from injuries that occured before the study period. Such acute episodes can occur long after the initial injury following an extended pain-free period. Since the guideline recommendations apply to each new acute episode, its use can result in significant savings for cases not included in this study. Future research will follow the cohort of new injuries analyzed in this study over time to look at patterns of continuing treatment for chronic and episodic acute cases.

1B. Guideline Development Process

In December 1994 the federal Agency for Health Care Policy and Research released its clinical practice guideline for treatment of acute low back pain (AHCPR 1994). This guideline was endorsed by AHCA in February 1995 for practitioners of medicine, osteopathic medicine, and chiropractic. It provides the .scientific basis for determining supported and non-supported diagnostic and therapeutic modalities for treatment of low back pain.

A year prior to the release of the federal guideline, AHCA formed a 25 member multi-specialty medical committee to prepare guidelines for the optimum use of medical and surgical procedures in the care of Florida's injured workers. The committee reexamined the protocols in the previously endorsed federal guideline and also considered additional scientific evidence for cases of chronic low back pain, an area not addressed by the federal guideline. The committee met 6 times from May 1994 through March 1995. Participation was voluntary and members paid their own travel and per diem expenses. The committee included the following members:

Robert C. Mumby, M.D. *Committee Chairman,* Orthopaedic Surgeon	Troy M. Tippett, M.D. *Neurological Surgery Subcommittee Chairman,* Neurosurgeon	
Robert Anderson, M.D. Neuro-radiologist	Raymond Bellamy, M.D. Orthopaedic Surgeon	Timothy Bullard, M.D. Emergency Medicine Specialist
Lawrence Cohen, M.D. Orthopaedic Surgeon	Rodolfo D. Eichberg, M.D. Physiatrist	Richard M. Fry, M.D. Orthopaedic Surgeon
Barth Green, M.D. Neurosurgeon	Walter C. Hollinger, M.D. Internal Medicine Specialist	Howard Hogshead, M.D. Orthopaedic Surgeon
Patrick Jacob, M.D. Neurosurgeon	S. H. Kori, M.D. Neurologist	G. Grady McBride, M.D. Orthopaedic Surgeon
Paul D. Seltzer, D.O. Orthopaedic Surgeon	Jock M. Sneddon, M.D. Primary Care	David M. Spalding, M.D. Rheumatologist

Daniel J. Sprehe, M.D. Psychiatrist	Thomas R. Sprenger, M.D. Orthopaedic Surgeon	T. Byron Thames, M.D. Primary Care
Michael Webb, M.D. Occupational Medicine Specialist	James L. West, M.D. Orthopaedic Surgeon	Albert A. Wilson, M.D. Orthopaedic Surgeon
Creighton L. Wilson, M.D. Orthopaedic Surgeon and Rehabilitation Specialist	Greg Zorman, M.D. Neurosurgeon	Anna Ohlson, R.N. Ex-officio member
James T. Howell, M.D. Ex-officio member	Alvin E. Smith, M.D. Ex-officio member	Christiane J. Guignard, R.N., M.S.N. Committee Coordinator

Early in its deliberations, the committee met with the Director of the Division of Workers' Compensation to discuss ways of making the guideline most effective in improving the quality and cost effectiveness of care provided to injured workers. Since injured workers are a very heterogeneous group, the committee decided to develop guidelines applicable to all patients. Therefore, the guideline was endorsed under two statutory authorities, section 408.02 of the Florida Health Care and Insurance Reform Act of 1993 and section 440.13(15) of the Workers' Compensation Reform Act of 1993.

The guideline contains algorithms depicting the process of patient care from intake through discharge. Protocols were classified into the following categories depending on the nature of the condition and its response to treatment: recommended, not recommended, not worth the cost, and insufficient evidence to recommend. Because section 440.13(15), F.S., establishes medical doctors and osteopathic doctors as clinical care coordinators, the guideline also includes protocols for them to refer patients to other practitioners representing professions with practice modalities supported by valid scientific evidence. These include practitioners of chiropractic, physical therapy, and occupational therapy.

In March 1995 AHCA held a public hearing to receive feedback on its draft low back guideline. During the seven months following the public hearing, the committee and the agency met extensively with Florida health services organizations to secure their input and obtain a multi-disciplinary, multi-specialty consensus on the guideline within the confines of valid scientific evidence. Organizations contributing to this process include:

Blue Cross and Blue Shield of Florida
Department of Labor, Division of Workers' Compensation
Florida Academy of Family Physicians
Florida Academy of Pain Medicine
Florida Allergy and Immunology Society
Florida Association of Occupational and Environmental Medicine
Florida Association of Pediatric Critical Care Medicine
Florida Association of Pediatric Surgeons
Florida Chapter, American College of Physicians

Florida Chapter, American College of Surgeons
Florida Chiropractic Association
Florida Chiropractic Society
Florida College of Emergency Physicians
Florida Geriatrics Society
Florida Medical Association
Florida Medical Directors Association
Florida Neurosurgical Society
Florida Occupational Therapy Association
Florida Orthopedic Society
Florida Osteopathic Medical Society
Florida Pediatrics Society
Florida Physical Therapy Association
Florida Psychiatry
Florida Psychiatry Council, American Psychiatric Association
Florida Radiological Society
Florida Society for Physical Medicine and Rehabilitation
Florida Society of Internal Medicine
Florida Society of Neurology
Florida Society of Rheumatology
Florida Surgical Society

In October 1995, AHCA officially endorsed the Florida low back guideline for treating patients with low back pain or injury. It was subsequently amended in February 1996 based upon new evidence regarding appropriate field strengths for magnetic resonance imaging. The guideline is subject to continuous review and is revised as new scientific evidence emerges.

AHCA Exceptions To 440.13(m)

AGENCY FOR HEALTH CARE ADMINISTRATION

Adopted into the Florida Administrative Code, March 4, 1996

CHAPTER 59B-11

EXCEPTIONS TO 440.13(m), FLORIDA STATUTES, COVERAGE OF EXPERIMENTAL AND INVESTIGATIVE PROCEDURES AND TREATMENTS UNDER RESEARCH

59B-11.001 Purpose. Section 440.13(2), Florida Statutes, requires employers to provide their injured employees such medically necessary treatment, care, and attendance as is required for the nature of their injury or process of recovery. "Medically necessary," as defined at section 440.13(1)(m), Florida Statutes, excludes all experimental, investigatory or research-related medical procedures and supplies unless they are appropriate to the injured employee's diagnosis and have been shown to have significant benefits to the recovery and well-being of the injured employee. Prior approval from the Agency for Health Care Administration must be obtained for an experimental, investigatory or research-related procedure or supply to be covered and compensable. When approached for a review by an employee, employer or carrier, the agency shall determine whether the procedure or supply is experimental, investigatory or of a research nature and then approve or disapprove the proposed procedure or medical supply on a case by case basis. These rules establish the criteria, procedures, and standards required to obtain the agency review.

Specific Authority:	440.13(1)(m), F.S.
Law Implemented:	440.13(1)(m), F.S, 440.13(2), F.S.
History:	New 3/4/96.

59B-11.002 Definitions. Unless otherwise specified in these rules, the terms and definitions contained herein shall have the same meaning as the terms and definitions contained in section 440.13(1), Florida Statutes (1993, Supp. 1994). In addition, the following definitions apply:

(1) "Agency or AHCA" means the Agency for Health Care Administration.

(2) "Division" means the Division of Workers' Compensation of the Department of Labor and Employment Security.

(3) "Review" means a review conducted by the agency to determine whether payment is appropriate under the Workers' Compensation Law for proposed medical procedures or supplies that may be classified as experimental, investigative, or of a research nature.

(4) "Experimental" describes a medical service, procedure, drug, equipment or supply which, for the particular diagnosis, the efficacy has not been proven and the safety and validity are unknown or unclear. This can but need not include treatments and procedures being tested in phase I and phase II clinical trials.

(5) "Investigative" describes a medical service, procedure, drug, equipment or supply which has been found safe and efficacious for the particular diagnosis but is still being investigated. The reliability, validity, efficacy and cost benefit of the service, procedure, drug, equipment or supply has not been conclusively demonstrated for use in treating or diagnosing the injury or illness being covered under worker's compensation medical benefits. This can but need not include treatments and procedures being tested in phase III clinical trials.

(6) "Research" means a scientific investigation, including research development, testing and evaluation. This term incorporates services, procedures, drugs and supplies that are being tested and that fall into the classifications experimental and investigational.

(7) "Reliable evidence" means practice parameters or guidelines endorsed by AHCA pursuant to sections 440.13(15), or 408.02, Florida Statutes, or sources of information where medical researchers have expressed their conclusions in a scientifically appropriate manner including peer-reviewed literature and articles published in medical and scientific journals.

(8) "Significant benefits to the recovery and well being of the injured employee" means that evidence indicates that the proposed procedure or supply is more likely than not, when compared with other treatment modalities, to promote the injured employee's ability to return to. gainful employment by maintaining or improving his or her functional condition. In cases where the injured employee cannot return to gainful employment, "significant benefits to the recovery and well being of the injured employee" means that the proposed procedure or supply is more likely than not, when compared with other treatment modalities, to promote the injured employee's ability to independently perform the activities of daily living.

(9) Phase I - III Clinical Trials are pre-planned studies of the safety, efficacy, or optimum dosage (if appropriate) of one or more diagnostic, therapeutic, or prophylactic drugs, devices, or techniques selected according to predetermined criteria of eligibility and observed for predefined evidence of favorable and unfavorable effects. The usefulness and efficacy of the procedure, drug or device is determined during Phase I and II Clinical Trials. Statistics are gathered on a large number of subjects during Phase III Clinical Trials.

Specific authority: 440.13 (1) (m), F.S.
Law Implemented: 440.13(1)(m), F.S.
History: New 3/4/96.

59B-11.003 Request for Agency Review.
(1) To have a case reviewed and receive a determination from the agency under this section, the carrier must submit a written request to the agency within twenty (20) working days from the time that the request for authorization for the proposed treatment or procedure is received by the carrier. Notwithstanding this time frame, the carrier must still comply with all response requirements specified in Section 440.13(3), Florida Statutes. A full copy of the written request for a review must be submitted to the injured employee or his attorney at the same time. The request must name the employer, the representative of the carrier, the injured employee and injured employee's attorney, the provider who has ordered or recommended the treatment or procedure, and the primary physician or provider (if different from provider proposing the treatment), with addresses and telephone numbers for all parties. A statement providing the date of the request for authorization by the injured employee or employee's representative must also be enclosed.

(2) Both the employee or provider and the employer or carrier shall be given the opportunity to submit pertinent medical records and documentation regarding the safety, efficacy and cost benefit or detriment of the proposed treatment to the agency. From the time that the request for an agency review is received by the agency, each party shall have twenty (20) working days within which to submit documentation and records to the agency. A copy of all submissions to the agency shall be provided to the injured employee or the employee's attorney within the same time frame. The approximate cost of the procedure, drug or device must be included in the documentation..

(3) When the formal request for an agency review is made, it shall be the responsibility of the party requesting the review to inform the other party of the opportunity to submit documentation and the time-frame for submission.

(4) If a case involving issues that would otherwise be determined by the agency under this section has gone to hearing before a Judge of Compensation Claims prior to either party formally requesting an agency review, parties shall be prohibited from requesting the review.

(5) If the Agency finds that a procedure or supply under review is not experimental, investigatory, or of a research nature, then it shall so state in its determination and shall not address any remaining issues of approval, all of which are in the competence and jurisdiction of the Judges of Compensation Claims.

Rulemaking Authority:	440.13(1)(m), F.S.
Law Implemented:	440.13(1)(m), F.S.
History:	New 3/4/96.

59B-11.004 Agency Review.
(1) The agency shall process each request for review, along with documentation regarding the safety and efficacy of the proposed treatment, procedure, or supply, and proposed benefits to the recovery and well-being of the injured employee submitted pursuant to these rules. Documentation must be based upon scientifically accepted criteria and demonstrated by more than one independent investigator or scientifically acceptable study.

(2) For each case, the agency shall provide medical records, cost information, and other appropriate documentation pursuant to these rules to a physician reviewer who has a prior agreement with the agency to perform such reviews. The reviewer shall be a licensed medical, osteopathic or chiropractic physician of the same or similar specialty as the treating physician, and shall be chosen by the agency. The physician reviewer shall review the records and shall advise the agency regarding whether the procedure, device or treatment should be approved pursuant to these rules.

(3) The agency shall not approve any treatment which is experimental or one that is being proposed as an integral part of a research project. A treatment that is classified as investigational may be approved if reliable evidence suggests that it will provide significant benefits toward the recovery and well being of the injured employee.

(4) In determining whether a proposed medical procedure or supply will provide significant benefits toward the recovery and well being of the injured employee, the agency shall consider the cost and benefits of the proposed procedure or supply with regard to injured employee's condition, case history, other similar case histories, and available alternative treatments.

(5) In making the determination for an approval, there must be reliable evidence indicating:

(a) that the proposed procedure or supply is safe and efficacious in relation to existing diagnostic or therapeutic alternatives,

(b) that the proposed procedure or supply will yield positive net beneficial effects on health outcomes that outweigh any harmful effects in relation to existing diagnostic or therapeutic alternatives, and

(c) that the positive net beneficial effects of the proposed procedure or supply outweigh the cost.

(6) Reviewers shall place substantial weight on results of clinical trials that have been performed. However, it is recognized that some widely-accepted, non-experimental medical treatments and procedures have not been subjected to the stringent phases of clinical trials. Thus, when the injured employee's condition is rare or terminal if left untreated, or when alternate treatments have not been effective or have not been effective in similar cases, and clinical trials have not clearly demonstrated efficacy of the proposed treatment, reviewers may still recommend approval of the proposed treatment for coverage.

(7) Drugs and medical devices may be approved by the Agency even when federal approval has not been granted as long as the drug or device is being tested in clinical trials approved by the Federal Food and Drug Administration (FDA) and when the drug or device otherwise meets the criteria of these rules.

Rulemaking Authority:	440.13(l)(m), F.S.
Law Implemented:	440.13(l)(m), F.S.
History:	New 3/4/96.

59B-11.005 Agency Determination. The agency shall make a final determination and provide written notification by certified mail to the injured employee or the injured employee's attorney, to the provider, to the employer and carrier, and to the Division of Workers' Compensation in the Department of Labor and Employment Security within forty (40) days from the closing date for submission of records and documents. Such notification shall include the following statement:

> Persons whose substantial interests are adversely affected by the agency's determination may request administrative review as provided by Section 120.57, Florida Statutes, and Rule 59-1.021, Florida Administrative Code.

Specific Authority: 440.015, F.S., 440.13(1)(m), F.S.
Law implemented: 120.57, FS, 440.13(1)(m), F.S.
History: New 3/4/96.

59B-11.006 Reimbursement Disputes. Nothing in these rules is intended to provide for agency resolution of any dispute regarding reimbursement of services which may arise pursuant to the agency's determination or the request for a determination. As required by the Workers' Compensation Law, any reimbursement dispute arising pursuant to the agency's administration of these rules shall be resolved in accordance with section 440.13(7), F.S., and the Division's adopted rules.

Rulemaking Authority: 440.13(1)(m), F.S.
Law Implemented: 440.13(1)(m), F.S., 440.13(7), F.S.
History: New 3/4/96.

DWC-25 Form And Instructions

For full instructions on completing the DWC-25, please visit www.fldfs.com/wc or contact:
Choice Provider Network
Provider Relations
888-823-5377

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 1

BEFORE COMPLETING THIS FORM, PLEASE CAREFULLY REVIEW THE INSTRUCTIONS BEGINNING ON PAGE 3

NOTE: Health care providers shall legibly and accurately complete all sections of this form, limiting their responses to their area of expertise.

1. Insurer Name:	2. Visit/Review Date:	5. FOR INSURER USE ONLY
3. Injured Employee (Patient) Name:	4. Date of Birth:	
6. Date of Accident:	7. Employer Name	8. Initial visit with this physician? ☐ a) NO ☐ b) YES

SECTION I CLINICAL ASSESSMENT / DETERMINATIONS

9. ☐ No change in Items 9 - 13d since last reported visit. If checked, GO TO SECTION II.

10. Injury/ Illness for which treatment is sought is:
☐ a) NOT WORK RELATED ☐ b) WORK RELATED ☐ c) UNDETERMINED as of this date

11. Has the patient been determined to have Objective Relevant Medical Findings? Pain or abnormal anatomical findings, in the absence of objective relevant medical findings, shall not be an indicator of injury and/or illness and are not compensable.
☐ a) NO ☐ b) YES ☐ c) UNDETERMINED as of this date
If YES or UNDETERMINED, explain:

12. Diagnosis(es):

13. Major Contributing Cause: When there is more than one contributing cause, the reported work-related injury must contribute more than 50% to the present condition and be based on the findings in Item 11.
a) Is there a pre-existing condition contributing to the current medical disorder?
☐ a_1) NO ☐ a_2) YES ☐ a_3) UNDETERMINED as of this date
b) Do the objective relevant medical findings identified in Item 11 represent an exacerbation (temporary worsening) or aggravation (progression) of a pre-existing condition?
☐ b_1) NO ☐ b_2) exacerbation ☐ b_3) aggravation ☐ b_4) UNDETERMINED as of this date
c) Are there other relevant co-morbidities that will need to be considered in evaluating or managing this patient?
☐ c_1) NO ☐ c_2) YES
d) Given your responses to the items above, is the injury/illness in question the major contributing cause for:
☐ d_1) NO ☐ d_2) YES the reported medical condition?
☐ d_3) NO ☐ d_4) YES the treatment recommended (management/treatment plan)?
☐ d_5) NO ☐ d_6) YES the functional limitations and restrictions determined?

SECTION II PATIENT CLASSIFICATION LEVEL

☐ 14. LEVEL I - Key issue: specific, well-defined medical condition, with clear correlation between objective relevant physical findings and patients' subjective complaints. Treatment correlates to the specific findings.

☐ 15. LEVEL II - Key issue: regional or generalized deconditioning (i.e. deficits in strength, flexibility, endurance, and motor control. Treatment: physical reconditioning and functional restoration.

☐ 16. LEVEL III -Key issue: poor correlation between patient's complaints and objective, relevant physical findings, indicating both somatic and non-somatic clinical factors. Treatment: interdisciplinary rehabilitation and management.

☐ 17. LEVEL UNDETERMINED AS OF THIS DATE.

SECTION III MANAGEMENT / TREATMENT PLAN

☐ 18. No clinical services indicated at this time. If checked, GO TO SECTION IV

☐ 19. No change in Items 20a - 20g since last report submitted. If checked, GO TO SECTION IV

20. The following proposed, subsequent clinical service(s) is/are deemed medically necessary.
*** THIS IS A PROVIDER'S WRITTEN REQUEST FOR INSURER AUTHORIZATION OF TREATMENT OR SERVICES. ***

☐ a) Consultation with or referral to a specialist. Identify principal physician: _____
Identify specialty & provide rationale: _____
☐ a_1) CONSULT ONLY ☐ a_2) REFERRAL & CO-MANAGE ☐ a_3) TRANSFER CARE

☐ b) Diagnostic Testing: (Specify) _____

☐ c) Physical Medicine. Check appropriate box and indicate specificity of services, frequency and duration below:
☐ c_1) Physical/Occupational therapy, Chiropractic, Osteopathic or comparable physical rehabilitation.
☐ c_2) Physical Reconditioning (Level II Patient Classification)
☐ c_3) Interdisciplinary Rehabilitation Program (Level III Patient Classification)
Specific instruction(s): _____

☐ d) Pharmaceutical(s) (specify): _____

☐ e) DME or Medical Supplies: _____

☐ f) Surgical Intervention - specify procedure(s):
☐ f_1) In-Office: _____
☐ f_2) Surgical Facility: _____
☐ f_3) Injectable(s) (e.g. pain management): _____

☐ g) Attendant Care: _____

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 2

Patient Name: D/A: Visit/Review Date:

SECTION IV FUNCTIONAL LIMITATIONS AND RESTRICTIONS

Assignment of limitations or restrictions must be based upon the injured employee's specific clinical dysfunction or status related to the work injury. However, the presence of objective relevant medical findings does not necessarily equate to an automatic limitation or restriction in function.

☐ 21 No functional limitations identified or restrictions prescribed as of the following date: _____

☐ 22. The injured workers' functional limitations and restrictions, identified in detail below, are of such severity that he/she cannot perform activities, even at a sedentary level (e.g. hospitalization, cognitive impairment, infection, contagion), as of the following date: _____ *Use additional sheet if needed.*

☐ 23. The injured worker may return to activities so long as he/she adheres to the functional limitations and restrictions identified below. Identify ONLY those functional activities that have specific limitations and restrictions for this patient. Identify joint and/or body part _____. Use additional sheet if needed.

Functional Activity	Load	Frequency & Duration	ROM/ Position & Other Parameters
☐ Bend			
☐ Carry			
☐ Climb			
☐ Grasp			
☐ Kneel			
☐ Lift-floor > waist			
☐ Lift-waist>overhead			
☐ Pull			
☐ Push			
☐ Reach-overhead			
☐ Sit			
☐ Squat			
☐ Stand			
☐ Twist			
☐ Walk			
☐			
☐ Other			

COMMENTS:

Other choices; Skin Contact/ Exposure; Sensory; Hand Dexterity; Cognitive; Crawl; Vision; Drive/Operate Heavy Equipment; Environmental Conditions: heat, cold, working at heights, vibration; Auditory; Specific Job Task(s); etc.

NOTE: Any functional limitations or restrictions assigned above apply to both on and off the job activities, and are in effect until the next scheduled appointment unless otherwise noted or modified prior to the appointment date.

Specify those functional limitations and restrictions, in Item 23, which are permanent if MMI / PIR have been assigned in Item 24.

SECTION V MAXIMUM MEDICAL IMPROVEMENT / PERMANENT IMPAIRMENT RATING

24. Patient has achieved maximum medical improvement?
☐ a) YES, Date: _____ ☐ b) NO ☐ c) Anticipated MMI date: _____
☐ d) Anticipated MMI date cannot be determined at this time. Future Medical Care Anticipated: e) ☐ Yes f) ☐ No
Comments: _____

25. _____% Permanent Impairment Rating (body as a whole) Body part/system: _____

26. Guide used for calculation of Permanent Impairment Rating (based on date of accident - see instructions):
☐ a) 1996 FL Uniform PIR Schedule ☐ b) Other, specify _____

27. Is a residual clinical dysfunction or residual functional loss anticipated for the work-related injury?
☐ a) YES ☐ b) NO ☐ c) Undetermined at this time.

SECTION VI FOLLOW-UP

28. **Next Scheduled Appointment Date & Time:**

SECTION VII ATTESTATION STATEMENT

"As the Physician, I hereby attest that all responses herein have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient." *"I certify to any MMI / PIR information provided in this form."*

Physician Group: _____ Date: _____
Physician Signature: _____ Physician DOH License #: _____
Physician Name: _____ Physician Specialty: _____
(print name)

If any direct billable services for this visit were rendered by a provider other than a physician, please complete sections below:

"I hereby attest that all responses herein relating to services I rendered have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."

Provider Signature: _____ Provider DOH License #: _____
Provider Name: _____ Date: _____
(print name)