

**WEST VIRGINIA
SECRETARY OF STATE
JOE MANCHIN, III
ADMINISTRATIVE LAW DIVISION**

Form #5

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2004 NOV 24 P 2:09

OFFICE WEST VIRGINIA
SECRETARY OF STATE

**NOTICE OF AGENCY ADOPTION OF A PROCEDURAL OR INTERPRETIVE RULE
OR A LEGISLATIVE RULE EXEMPT FROM LEGISLATIVE REVIEW**

AGENCY: Workers' Compensation Commission TITLE NUMBER: 85

CITE AUTHORITY: W. Va. Code §§23-1-1a(j)(3), 23-4-1 et seq.

RULE TYPE: PROCEDURAL _____ INTERPRETIVE _____

EXEMPT LEGISLATIVE RULE X

CITE STATUTE(S) GRANTING EXEMPTION FROM LEGISLATIVE REVIEW

W. Va. Code §§23-1-1a(j)(3)

AMENDMENT TO AN EXISTING RULE: YES _____ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: 21

TITLE OF RULE BEING PROPOSED: Managed Health Care Plans

THE ABOVE RULE IS HEREBY ADOPTED AND FILED WITH THE SECRETARY OF STATE. THE

EFFECTIVE DATE OF THIS RULE IS January 1, 2005



Authorized Signature

**WEST VIRGINIA
SECRETARY OF STATE
JOE MANCHIN, III
ADMINISTRATIVE LAW DIVISION**

Form #1

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2004 SEP 21 P 3

OFFICE WEST VIRGINIA
SECRETARY OF STATE

NOTICE OF A PUBLIC HEARING ON A PROPOSED RULE

AGENCY: Workers' Compensation Commission TITLE NUMBER: 85

RULE TYPE: Exempt Legislative CITE AUTHORITY: W. Va. Code §§23-1-1a(j)(3); 23-4-1 et seq.

AMENDMENT TO AN EXISTING RULE: YES ___ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: 21

TITLE OF RULE BEING PROPOSED: "Managed Health Care Plans"

DATE OF PUBLIC HEARING: October 26, 2004 TIME: 1:00 p.m.

LOCATION OF PUBLIC HEARING: Rooms 207-209
Charleston Civic Center
Charleston, West Virginia


COMMENTS LIMITED TO: ORAL ___ , WRITTEN ___ , BOTH X
COMMENTS MAY ALSO BE MAILED TO THE FOLLOWING ADDRESS:

The Department requests that persons wishing to make comments at the hearing make an effort to submit written comments in order to facilitate the review of these comments.

The issues to be heard shall be limited to the proposed rule.

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL

T. J. Obrokta, General Counsel
Executive Office
Workers' Compensation Commission
4700 MacCorkle Ave., S.E.
Charleston, West Virginia 25304
Fax # (304) 926-5372



Authorized Signature



4700 MacCorkle Avenue, S. E.
Charleston, West Virginia 25304
Phone: (304) 926-3400

Gregory A. Burton, Executive Director

September 21, 2004

The Honorable Joe Manchin III
Secretary of State
State Capitol Complex
Building 1, Room W-157
Charleston, West Virginia 25305

Re: Proposed Rule
Title 85, Series 21
"Managed Health Care Plans"

Dear Secretary Manchin:

Please consider this letter to be my written approval for the filing of the above-noted proposed Rule.

Pursuant to Senate Bill 2013, Second Extraordinary Session, 2003, the Workers' Compensation Commission is established as a government entity separate from the Bureau of Employment Programs. Pursuant to that same bill, the Board of Managers of the Workers' Compensation Commission has approved the enclosed 85 C.S.R. 21 entitled, "Managed Health Care Plans," for filing as a proposed rule of the Workers' Compensation Commission.

Thank you very much for your assistance in this matter.

Very truly yours,

A handwritten signature in black ink, appearing to read 'G. A. Burton'.

Gregory A. Burton
Executive Director

Enclosure

**SUMMARY OF PROPOSED RULE
STATEMENT OF CIRCUMSTANCES
TITLE 85, SERIES 21
Managed Health Care Plans**

FILED

2004 SEP 21 P 3:28

OFFICE WEST VIRGINIA
SECRETARY OF STATE

This rule establishes the requirements and procedures to be followed by the Commission, parties to pending claims, employers and managed health care plan administrators involved in the delivery or proposed delivery of managed care to injured workers.

Pursuant to Senate Bill 2013, Second Extraordinary Session, 2003, the Workers' Compensation Commission was created, effective October 1, 2003, as a stand-alone agency of State government. Pursuant to Senate Bill 2013 and also effective October 1, 2003, the Compensation Programs Performance Council was abolished and replaced by the Workers' Compensation Commission's Board of Managers.

Under S. B. 2013, the Commission is authorized to create managed health care plans. See: W. Va. Code §23-4-3(b)(2).

The purpose of the proposed rule is to assist workers to return to work as soon as practicable after a compensable injury and otherwise provide for high quality, cost effective medical care to injured workers.

The proposed rule establishes:

- (1) Minimum Managed Health Care Plan standards;
- (2) The Managed Health Care Plan application process;
- (3) The Commission's approval process for Managed Health Care Plans;
- (4) The approval process for Managed health Care Plan modifications;
- (5) The procedure by which a certified Managed Health Care plan may have its certification suspended or revoked;
- (6) Provisions for an informal grievance process to resolve disputes by employees and providers relative to the rendition of medical services;
- (7) Reporting requirements for Managed Health Care Plans;
- (8) The provision to injured workers by their employers of a written certification of workers' compensation managed health care coverage; and
- (9) Standards under which injured workers may access health providers who are not participating in the Managed Health Care Plan.

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Title 85, Series 21, Managed Health Care Plans

Type of Rule: X Legislative Exempt Interpretive Procedural

Agency Workers' Compensation Commission

Address 4700 MacCorkle Avenue, S.E.

Charleston, WV 25301

1. Effect of Proposed Rule

	ANNUAL FISCAL YEAR				
	INCREASE	DECREASE	CURRENT	NEXT	THEREAFTER
<u>ESTIMATED TOTAL COST</u>	\$0	Unknown	Decrease	Decrease	Decrease
PERSONAL SERVICES	0	0	0	0	0
CURRENT EXPENSE	0	0	0	0	0
REPAIRS & ALTERNATIONS	0	0	0	0	0
EQUIPMENT	0	0	0	0	0
OTHER:					
Claims expense	0	Unknown	Decrease	Decrease	Decrease

2. Explanation of above estimates:

The proposed rule establishes the application, approval and revocation processes for managed health care plans. It also defines the minimum plan standards, including other administrative provisions governing the operation of managed health care plans, in order to provide high quality, cost effective medical care to injured workers. Some additional personnel costs may be incurred by the Commission to review applications and to perform the any review and/or audit of approved plans for adherence to the established standards and guidelines, including the monitoring of any grievances. However, any additional personnel costs should be insignificant. The proposed rule also provides for the oversight of the care and treatment of injured workers' compensable injuries through ongoing quality assurance programs, utilization reviews and dispute resolution processes performed by the approved managed health care plans. This should help to achieve cost effective medical care for injured workers and result in medical savings. However, there is no historical data readily available to estimate the reduction in claims medical costs that will be realized as a result of utilizing managed health care plans.

Rule Title: Title 85, Series 21, Managed Health Care Plans

3. Objectives of this rule:

The purpose of this rule is to define the standards, guidelines and process for utilizing managed health care systems to assist in providing high quality, cost effective medical care to injured workers.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

It is expected that this rule will assist the Commission in providing more effective, thorough, and consistent health care for injured workers and will result in savings in workers' compensation medical costs.

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of Citizens.

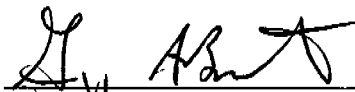
It is expected that the rule will improve medical claims management, and help to deter escalating medical costs for employers. Also, it is expected that managed health care will lead to better health care of injured workers, and assist in their return to the workforce.

C. Economic Impact on Citizens/Public at Large.

This rule will not have a direct economic impact on the citizens of West Virginia.

Date: 9-21-04

Signature of Agency Head or Authorized Representative



Gregory A. Burton
Executive Director, Workers' Compensation Commission

FILED

TITLE 85
EXEMPT LEGISLATIVE RULE
WORKERS' COMPENSATION COMMISSION
SERIES 21
MANAGED HEALTH CARE PLANS

2004 NOV 24 P 2:09
OFFICE WEST VIRGINIA
SECRETARY OF STATE

§85-21-1. General.

1.1. Scope. --This exempt legislative rule establishes the requirements and procedures to be followed by the West Virginia Workers' Compensation Commission, parties to claims pending before the Commission, employers, and managed health care plan administrators and others involved in the delivery or proposed delivery of managed care to injured workers pursuant to W. Va. Code §23-4-3(b)(2).

1.2. Authority. -- W. Va. Code §23-4-3(b)(2). Pursuant to W. Va. Code Section §23-1-1a(j)(3), rules adopted by the Workers Compensation Board of Managers are not subject to legislative approval as would otherwise be required under W. Va. Code Section § 29A-3-1 et seq. Public notice requirements of that chapter and article, however, must be followed.

1.3. Filing Date. --

1.4. Effective Date. --

§85-21-2. Purpose of Rule; Cooperation.

It is a goal of the workers' compensation program to assist workers to return to work as soon as practicable after a compensable injury and to otherwise provide for high quality, cost effective medical care to injured workers. It is the shared responsibility of the employer, the injured worker, the managed health care plan, and the Commission to cooperate to achieve this goal.

§85-21-3. Definitions.

As used in this exempt legislative rule, the following terms have the stated meanings unless the context of a specific use clearly indicates another meaning is intended.

3.1. "Executive Director" means the executive director of the West Virginia Workers' Compensation Commission pursuant to W.Va. Code §23-1-1b.

3.2. "Commission" means the West Virginia Workers' Compensation Commission as provided for by W. Va. Code §23-1-1.

3.3. "Injury" and derivative words have the meaning ascribed to the term "injury" by W. Va. Code §23-4-1.

3.4. "Injured worker" and "claimant" mean an employee entitled to workers' compensation benefits as the result of a work-related injury, as provided under W. Va. Code §23-4-1.

3.5. "Employer" has the meaning ascribed to that term by W. Va. Code §23-2-1, which includes, but is not limited to, any individual, sole proprietor, firm, partnership, limited partnership, limited liability company, joint venture, association, corporation, company, organization, receiver, estate, trust, guardian, executor, administrator, government entity or any other entity regularly employing another person or persons for the purpose of carrying on any form of industry, service or business in this state.

3.6. "Managed health care plan" means a plan that establishes, operates, or maintains a network of health care providers that have entered into agreements with the plan to provide health care services to injured workers to whom the plan has the ultimate obligation to arrange for the provision of or payment for services through organizational arrangements for ongoing quality assurance, utilization review programs, or dispute resolution.

3.7. "Provider" means any physician, hospital or other person or organization, which is licensed or otherwise authorized in this state to provide health care services or supplies.

3.8. "Utilization review" means the critical examination of health care services provided to patients especially for the purpose of controlling costs and monitoring the quality of care.

§85-21-4. Minimum Plan Standards

4.1. Employers, ~~or~~ managed health care plans acting on their behalf, or third party administrators may submit to the Commission a proposed managed health care plan and if approved, can require its injured workers to use health care providers authorized by the managed health care plan for care and treatment of the injured workers' compensable injuries. The Commission retains sole discretion in approving proposed managed health care plans. All managed health care plans submitted for approval shall include the following features:

a. Co-payments or deductibles shall not be required for medical services rendered in connection with a work-related injury or occupational disease;

b. The injured worker shall be allowed a reasonable choice of providers within the plan;

c. Adequate specialty and subspecialty providers, and general and specialty hospitals must be provided for to afford employees reasonable choice and convenient geographic accessibility to all categories of licensed care. Primary care available within 75 driving miles of the employer's facility is presumed to be geographically reasonable unless the standard of care within the community extends this distance. The availability of secondary and tertiary care shall not be governed by the 75 mile standard;

d. The managed health care system shall provide an informal procedure for the expeditious resolution of disputes concerning rendition of medical services;

e. The employee shall be allowed to obtain a second opinion, at the employer's expense, from a qualified physician within the plan, if available, if a managed health care system physician recommends surgery;

f. The managed health care system shall establish procedures for utilization review of medical services to assure that a course of treatment is medically necessary; diagnostic procedures are not unnecessarily duplicated; the frequency, scope, and duration of treatment is appropriate; pharmaceuticals are not unnecessarily prescribed; and that ongoing and proposed treatment is not experimental, cost ineffective, or harmful to the employee;

g. Mechanisms for utilization review which shall prevent inappropriate, excessive, or medically unnecessary medical services and including:

1. Treatment standards upon which utilization review decisions shall be based (including low back symptoms and injuries to the upper extremities and knees) assuring quality care in accordance with prevailing standards in the medical community of which the plan provider is a member. The standards shall conform to any practice parameters or guidelines for clinical practice adopted by the Commission;

2. Mechanisms requiring periodic review to determine that continued treatment of an injured employee is reasonable, appropriate, and medically necessary;

3. Assurance that the managed health care system is conducting utilization review; and

4. Adequate procedures for credentialing providers and evaluating the quality and cost effectiveness of services delivered under the plan.

h. Statements for services shall be audited regularly to assure that charges are not duplicated and do not exceed those authorized ~~in the applicable fee schedules;~~ by the particular plan;

i. Restrictions on provider selection imposed by a managed health care plan authorized by this chapter shall not apply to emergency medical care;

k. Provisions to allow for the Commission to audit the managed health care plan's operations;

l. Effective methods of informing employees, employers, and medical providers of the services provided by the plan and requirements imposed by the plan, including a twenty-four (24) hour toll free phone number by which information may be obtained concerning plan operations, after-office-hours care, and twenty-four (24) hour access to emergency care;

m. A system to provide authorization to medical providers and health facilities where preauthorization or continued stay review is required by the plan. The authorization shall be recorded in the treatment section of the appropriate billing forms;

n. Case management by either a certified case manager, certified rehabilitation counselor, certified insurance rehabilitation specialist, or a certified rehabilitation registered nurse to coordinate the delivery of health services and return to work policies; promote an appropriate, prompt return to work; and facilitate communication between the employee, employer, and health care providers. The plan shall describe the circumstances under which injured employees shall be subject to case management and the services to be provided;

o. The managed health care plan must be owned and operated by an organization or entity sufficiently unrelated and independent of the employer in terms of ownership and control so that it can demonstrate independence from said employer; and

p. The managed health care plan shall have a medical director to fulfill the duties set forth in this exempt legislative rule and to perform other duties customarily associated with the medical director of a managed health care plan.

4.2. This rule shall not preclude or otherwise limit an injured workers' right to seek care from a provider outside the approved plan or approved opt-out provider at his or her own expense.

§85-21-5. Application Process

5.1. The following process shall govern the application process for managed health care plans submitted to the Commission for approval pursuant to West Virginia Code Section 23-4-3(b)(2). All managed health care plans must be approved by the Commission before utilized. Employers may participate in one (1) or more approved managed health care plans. Applications for initial certification and renewal shall be submitted, in triplicate, in a form acceptable to the Commission and shall contain the following information:

a. Plan identification.

1. Plan name and address.
2. Date and state of incorporation.
3. Name, address, and phone number of each corporate officer and director, and of the person who will be the day-to-day plan administrator.
4. Name and address of each owner of more than five (5) percent of the stock or controlling interest in the entity.
5. Name, address, and phone number of the medical director, who shall be a medical doctor (M.D. or D.O. physician) and who shall oversee and monitor compliance with the quality care, utilization review and credentialing provisions of the managed care plan.

6. Name, address, and phone number of the case manager who shall be qualified as either a certified case manager, certified rehabilitation counselor, certified insurance rehabilitation specialist, or certified rehabilitation registered nurse who shall oversee and monitor case management provisions of the managed care plan.

7. Description of the system's organizational structure.

b. Plan qualifications.

1. Description and map of the plan's service area.

2. Name, address, phone number, and specialty of all participating providers. The plan shall provide assurance that all licensing, registration, or certification requirements have been met and are current for the providers to practice in West Virginia (or border states wherein the provider practices) and that each participating provider shall maintain in full force and effect a professional malpractice policy with limits of no less than \$1,000,000 for an occurrence of professional negligence.

negligence, unless the Commission determines, in its sole discretion, that a different malpractice limit is more appropriate given the providers' specialty or discipline.

3. A specimen of the agreement that each class of medical provider shall execute to participate in the plan.

4. Specimens of the materials which the plan shall provide to workers setting forth the grievance procedure and form, the requirements and restrictions of the plan, and the means of accessing services and treatment within and outside of the service area. The applicant shall detail the time and means by which the materials shall be delivered to employees and employers.

5. Specimens of materials directed at management employees informing supervisors of the necessity of channeling injured workers to the managed health care plan providers and giving immediate notice to the employer, insurance carrier, and plan of the occurrence of an injury.

c. Financial Ability. Each managed health care plan shall demonstrate to the Commission that it has sufficient financial resources and professional expertise to perform all of the necessary functions of a managed health care plan. Each managed health care plan requesting certification shall demonstrate such resources and ability to the Commission by the following:

1. In the event the applicant has previously provided managed care or other similar medical and administrative services in West Virginia, the applicant shall provide a summary and description of the administrative and medical services provided, together with a list of representative entities for which managed care related administrative or medical services have been provided; and

2. In the event the applicant has not previously provided services related to the delivery of managed care in West Virginia, it shall be required that, prior to certification, that the applicant post either a performance bond, cash surety deposit, bank letter of credit, or other approved instrument in an amount of \$500,000 with the Commission to demonstrate sufficient financial resources to provide all of the administrative and medical services required to be performed under a managed care plan. The bond or cash surety shall be released by the Commission sixty (60) days after the managed health care system demonstrates to the Commission that all of its arrangements for rendering workers' compensation managed care services in the state have been terminated.

3. If the applicant has an audited financial statement addressing any of its prior operations for the preceding year, a copy of the applicant's most recent audited financial statement shall be submitted to the Commission.

§85-21-6. Approval by the Commission

6.1. The Commission shall notify the applicant in writing of the determination made upon the application for certification or modification thereof, within sixty (60) days of receipt of a complete application. A denial shall be final and unappealable.

6.2. A certificate shall be valid for a period of two (2) years and only for the service area and managed care plan or plans specified by the Commission. Upon written request made at least sixty (60) days prior to expiration of the current certificate, the Commission may recertify a plan for additional successive two (2) year periods. Geographical areas may be added upon the filing of a supplemental application demonstrating the managed health care system's ability to serve the expanded area.

6.3. If an application does not meet the requirements for certification or expansion, the Commission shall notify the applicant in writing and specify those items deemed deficient. The applicant is granted thirty (30) days from the date of notice by the Commission to correct deficiencies through an amended application.

6.4. Certifications of a managed care plan are not transferable. A new application for certification must be filed when fifty (50) percent or more of the ownership or controlling interest of a system has been transferred.

§85-21-7. Plan Modifications.

7.1. A managed health care plan, which either implements or experiences material variations as to any matter set forth in the original application or managed care plan, shall obtain approval for the modification by filing a request for modification with the Commission.

a. Intended variations shall not be implemented until approved by the Commission.

b. A modification outside the control of the system shall be filed with the Commission within fifteen (15) days of its occurrence.

7.2. Within fifteen (15) days of entering into an agreement with an employer or insurer to provide workers' compensation managed care services, the managed health care plan shall submit notification thereof to the Commission. The notification shall identify the employer or employers with whom the managed health care plan has contracted and the certified managed care plan applicable to that employer. Notification shall be deemed approved unless disapproved by the Commission in writing within thirty (30) days of filing. The plan shall promptly furnish any information deemed necessary by the Commission to review the notice. When an employer or insurer terminates a contract with a managed health care plan, the managed health care plan shall file notification with the Commission within fifteen (15) days of the occurrence, indicating the employers for whom managed care services have been terminated and the effective date of the termination.

§85-21-8. Suspension or Revocation of Certification.

8.1. The certification of a managed care plan by the Commission may be suspended or revoked if:

a. Service is not being provided according to the terms of the certified managed care plan, or in accordance with prevailing treatment standards, or in accordance with treatment standards or practice parameters adopted by the Commission;

b. The plan for providing services or the contract with the insurer or health care provider fails to meet the requirements of the West Virginia Code or applicable state rules and regulations;

c. Any material false or misleading information is intentionally submitted by the managed health care system or participating provider to the Commission, the employer, or the insurer;

d. The managed health care system knowingly or negligently utilizes a health care provider whose license, registration, or certification has been suspended or revoked, or who is otherwise ineligible to provide treatment of the type rendered to an injured employee; or

e. For any other good faith basis as determined in the sole discretion of the Commission.

8.2. The Commission may investigate the operations of a certified managed health care plan at any time and the plan and its providers shall cooperate in any investigation by the Commission. Should the Commission ~~believe~~ find that reasonable grounds for termination or suspension of a managed care plan certification exist, written notice setting forth those grounds shall be mailed to the system by certified mail, return receipt requested. The system is granted fifteen (15) days from the date of the verified receipt of or refusal of the notice in which to file written response. Thereafter, the Commission shall render a written decision by which the certification of the plan may be terminated, suspended, or conditionally continued to permit the correction of deficiencies directed. The Commission's decision is final and unappealable.

§85-21-9. Other Administrative Provisions.

9.1. An employee who reports an injury alleged to be work-related or files an application for adjustment of a claim shall execute a waiver and consent of any ~~physician-patient, psychiatrist-~~

~~patient, or chiropractor-patient~~ privilege with respect to any condition or complaint reasonably related to the condition for which the employee claims compensation. Notwithstanding any other provision of the West Virginia Code, any physician, psychiatrist, chiropractor, podiatrist, hospital, or health care provider shall, within a reasonable time after written request by the employee, employer, or Commission provide the requesting party with any information or written material reasonably related to any injury or disease for which the employee claims compensation.

9.2. When a provider of medical services or treatment makes referrals for medical services or treatment to a provider or entity in which the provider making the referral has an investment interest, the referring provider shall disclose that investment interest to the employee, the Commission and the employer or the third party administrator responsible for paying for the medical services or treatment, within thirty (30) days from the date the referral was made.

9.4. Employers may contract with multiple managed health care plans in order to maximize access for their employees.

§85-21-10. Minimum Grievance Standards.

10.1. Each workers' compensation managed care plan shall contain an expeditious, informal grievance procedure to resolve disputes by employees and providers relative to the rendition of medical services. A detailed description of the employee grievance procedure shall be included in informational materials provided to employees and a detailed description of the provider grievance procedure shall be included in all provider contracts.

10.2. The grievance procedure shall meet the following minimum requirements:

a. Notice. A grievance is made when a written complaint or written request is delivered by the employee or provider to the managed health care system setting forth the nature of the complaint and remedial action requested.

b. Time frame to file grievance. The employee or provider shall file a grievance within thirty (30) days of the occurrence of the event giving rise to the dispute.

c. Resolution. The managed health care system shall render a written decision upon a grievance within thirty (30) days of receipt by the managed health care system of the grievance.

d. Arbitration. Managed care plans may provide for alternate means of dispute resolution including arbitration and mediation. In that event final resolution of a grievance shall not be subject to the time constraints set forth in paragraph c of this subsection. In all cases, resolution mechanisms shall be expeditious and where treatment matters are at issue reflect the need for prompt resolution.

10.3. Record of grievance proceedings. The managed health care plan shall maintain records for two (2) years of each formal grievance to include the following:

a. A description of the grievance; the employee's name and address; names and addresses of the health care providers relevant to the grievance; and the managed health care system's and employer's name and address; and

b. A description of the managed health care system's findings, conclusions, and disposition of the grievance.

10.4. Appeal. The managed health care plan shall notify the applicable self-insured employer or the Commission of its final decision so that either the self-insured employer or the Commission can issue a protestable order setting forth the decision. The Commission's role is administrative only and it will not rule on the merits of the dispute. The time period set forth in the West Virginia Code to protest to the Office of Judges shall begin to run upon issuance of the protestable order and shall be tolled until that time.

§85-21-11. Reporting Requirements.

11.1. Each certified managed health care plan shall submit a report to the Commission semi-annually containing the following information:

- a. Number of employees treated by the managed care plan;
- b. Number of work-related injuries or diseases by ICD-9 code treated under the managed care plan in the preceding year;
- c. Breakdown by ICD-9 codes of injuries and diseases treated;
- d. Total medical costs;
- e. Average medical cost per injured employee by type of injury;
- f. Average medical cost per diseased employee by type of disease;
- g. Breakdown of medical cost elements as to type of physician utilized, hospital costs, drug costs, and other costs;
- h. Number of grievances filed, and summary of action taken; and
- i. Number of days by type of injury and disease for which an employee has been released from work.

§85-21-12. Provider Verification.

12.1. Each employer which provides medical services through a managed care plan will provide to the injured employee a written certification of workers' compensation managed care coverage as soon as practicable following notice of a compensable injury or disease requiring medical services. The verification shall contain the following information:

- a. Employer name, address, and phone number;
- b. Name and telephone number of the managed health care system to be contacted; and
- c. Employee name and Social Security number.

12.2. Possession of such verification is not to be construed as authorization for medical service or payment.

§85-21-13. Injured Worker Opt-Out Standards.

13.1. Injured workers may access providers who are not participating plan providers:

- a. For emergency care when access to a health care provider within the managed health care plan is unobtainable for the acute phase of care;
- b. When authorized treatment is unavailable through the managed care plan; or
- c. To obtain a second opinion when a managed health care plan physician recommends surgery and another qualified physician within the plan is not available for consultation.

13.2. Injured workers may access providers who are not participating plan providers for treatment purposes only if the injured worker has established by competent evidence all of the following:

- a. The injured worker has been treated by providers solely within the employer's managed care plan for a period of at least one (1) year;
- b. That for reasons related to the treatment alone, the injured worker has not made progress toward recovery that is reasonably consistent with the Commission's treatment guidelines;
- c. That the injured worker establishes to a reasonable certainty that proposed treatment outside the employer's managed care plan would more likely provide the injured worker with a better clinical outcome than the current treatment or rehabilitation plan; and
- d. A condition of the right to opt out under this provision shall be that the services secured outside the plan are for treatment purposes only and the provider shall not be permitted to rate the injured worker for permanent partial or permanent total disability. Any provider providing services pursuant to this provision shall be barred from providing such a rating.

§85-21-14. Severability.

If any provision of these rules or the application thereof to any entity or circumstance is held invalid, the invalidity will not effect the provisions or the applications of these rules which can be given affect without the invalid provisions or application and to this end the provisions of these rules are declared to be severable.

ORIGINAL

BEFORE THE
WEST VIRGINIA WORKERS' COMPENSATION
BOARD OF MANAGERS

IN THE MATTER OF:
PUBLIC HEARING
(OCTOBER 26, 2004)

) STEVE WHITE, CHAIRMAN
) RULE 21 - MANAGED HEALTH
) CARE PLAN

Transcript of proceedings had in the above-styled meeting were held as therein appears before the WEST VIRGINIA WORKERS' COMPENSATION BOARD OF MANAGERS held at the Charleston Civic Center, Suite 206, 200 Civic Center Drive, Charleston, West Virginia, at 1:41 p.m., on the 26th day of October, 2004.

BILLANTI AND ASSOCIATES
COURT REPORTERS
1033 RIDGEMONT DRIVE
ELKVIEW, WV 25071
304-965-7444

**APPEARANCES:
MEMBERS OF THE WEST VIRGINIA
WORKERS' COMPENSATION BOARD OF MANAGERS**

STEVE WHITE, Chairman

DOUGLAS MERRITT, Member

PAUL THOMPSON, Member

EVERETTE SULLIVAN, Member

GENE BAILEY, Member

BOB PHALEN, Member

MARGARET RICE, Recording Secretary

INDEX:

SPEAKERS

PAGE

PHILLIP STOWERS

3

Reporter's Certificate.....16

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

(P R O C E E D I N G S)

(1:41 P.M)

CHAIRMAN WHITE: The next rule before us that we will have a public hearing on is Rule 21, Managed Health Care Plans. Again, this rule was passed previously by the Board of Managers with reference to the Secretary of State's office for a period of public comment. This is the public comment period and it is now open for public comment.

I have before me the individuals who signed to speak to this rule. I'd like to call Mr. Phillip Stowers.

MR. STOWERS: Steve, may I pass out my comments?

CHAIRMAN BLACK: Sure.

(Mr. Stowers hands documents to the Committee members.)

MR. STOWERS: As many of you know, my name is Phillips Stowers. I'm an attorney here in town and for the last two decades, I've presented the chiropractic profession in West Virginia.

1 We have seen in the evolution of the
2 rules process we are in a particular type of focus
3 on chiropractic and some different issues. We
4 have worked a lot with the Commission on the rules
5 that are related to physical medicine and worked
6 through those in the last process.

7 It's important, I think, for you to
8 understand, that for the majority of the
9 chiropractic profession they offer very effective
10 services that keeps chiropractic and Workers'
11 Compensation claims lower; that when you eliminate
12 further chiropractic benefits, you are increasing
13 not only the days off work, but you are also going
14 to increase the medical costs.

15 I believe there's been sufficient
16 empirical data that shows specifically that
17 chiropractic care is more effective both from a
18 time of working standpoint, as well as a medical
19 cost overall standpoint.

20 What's important about this managed
21 care rule, as we think about chiropractic
22 globally, is just one comment I'd like to have

1 before I go to my written comments, and that is
2 that you are trying to incorporate, which you
3 will, managed care and Workers' Comp into combined
4 plans.

5 Although we have been assured by
6 counsel that there will be a transition through
7 this process that we have worked so hard on
8 physical medicine rules, that each managed care
9 plan will honor those physical medicine rules.

10 You have to understand that there is
11 a myriad of health care plans out there. Every
12 managed care plan that I see in my office for the
13 last 15 years has a different physical medicine
14 rule to it, a different regulation or a different
15 chiropractic benefit.

16 There are still U.M.W.A. policies
17 that don't provide for any chiropractic care at
18 all in the health care benefit.

19 In that regard, when you start
20 trying to incorporate claim's managers that aren't
21 the fund, but when claim's managers are outside
22 the system trying to administer a health care

1 plan, as well as a Workers' Compensation plan, the
2 enormous confusion unless there is something done
3 specifically to direct them in handling the
4 chiropractic claims.

5 There's no way to seamlessly
6 integrate the chiropractic benefit of Workers'
7 Comp into managed health care plans, because it's
8 different. It's different on almost every plan.
9 That's not just necessarily for chiropractic, but
10 it is for physical medicine across the board.

11 Just before I get to my points, I
12 just wanted to make an observation to you to help
13 work with us and make sure that we have this
14 transition that's possible in moving managed care
15 and managed compensation claims together and that
16 the most effective physical medicine providers,
17 chiropractic and their ability to rehab and return
18 to work, are not somewhere squashed in this whole
19 process.

20 To look at my specific concerns, the
21 first concern identified is on page 1 of the
22 rules. On the first page of the rules, Section

1 85-21-4.1.b, all that rule provides there is that
2 it doesn't provide any requirement that there be
3 sufficient providers in the plan of type of
4 providers.

5 The reason I think that's important
6 is that while the plan tells us or while the
7 document tells us that we are going to have
8 sufficient providers in a plan, we are talking
9 about types of providers.

10 The reason I say that is because,
11 again, when managed care companies impanel
12 chiropractors, you are going to deal with managed
13 care plans that have never impaneled chiropractors
14 before, because they have never offered a
15 chiropractic benefit in their health care plan and
16 so it's very important, I think, in the rule to
17 make sure that in -- I guess it's on page 2, but
18 it's in the b, it says, "The injured worker shall
19 be allowed a reasonable choice of providers within
20 the plan."

21 I think also when we are evaluating
22 the minimum plan standards, we have to make sure,

1 and I would like to see the language, that the
2 plan demonstrate that it includes sufficient
3 numbers of each type of licensed medical provider
4 that is approved to provide medical services by
5 the Commission; because while it may be very
6 important to protect the right of the injured
7 worker to have reasonable choice, it's also
8 important to have sufficient providers in the
9 managed care plans so that that reasonable choice
10 of type of provider is also protected.

11 We know that the global choice of
12 physician was eliminated in this rule; that you
13 took away historically or you seek to take away
14 historically, and the legislature did in the
15 statute, to take away the choice of provider and
16 this whole idea of the company doctor, and you
17 have had all the labor people talking to you about
18 that.

19 What I'm talking about is not that
20 the chiropractors or the physical medicine
21 providers together want to be the company doctors
22 or they want to be thrown out of this whole

1 process when the company doctors come back into
2 being. The rule says that managed care plans have
3 to be separate and distinct from the employers so
4 we are going to avoid this company doctor idea.
5 That's fine.

6 What I'm saying is that when you are
7 dealing with an employer that has a health care
8 plan that has never had a rehabilitative
9 chiropractic benefit in it, then before that plan
10 is approved by this fund, you ought to at least
11 make sure that plan has impaneled credentialed and
12 brought on board sufficient chiropractors to
13 provide a chiropractic service that the plan says
14 that's appropriate under the rules you have
15 already passed.

16 I just think that's an important and
17 a very essential part of what your council needs
18 to do.

19 To conclude on this point, I would
20 just say that we have already worked really hard,
21 over a year, on physical medicine guidelines and
22 these guidelines provide for chiropractic

1 benefits.

2 They provide for rehabilitation and
3 they guide how we handle physical medicine claims.
4 But now we are going to look at trying to
5 incorporate managed care plans that never
6 recognized those types of guidelines, on top of
7 guidelines you tell them they have to recognize. I
8 just hope before those plans are approved, they
9 have to certify to the Commission that they have
10 sufficient impaneled chiropractors to provide the
11 chiropractic benefit.

12 My second point on the written
13 comments is Point 2. I've inserted, not
14 haphazardly, under "Minimum plan standards," but I
15 think that would be the place I would find it if I
16 was drafting this rule, and that is that there
17 ought to be a provision -- the law itself, West
18 Virginia Code 23-4-3(b)(2) says that there shall
19 be criteria determined by rule that allows a
20 person to seek health care outside the employer's
21 panel of providers.

22 And nowhere in this rule or where I

1 think it probably would be in "minimum standards"
2 is there a criteria set by rule that allows the
3 employee to request and obtain written approval to
4 seek care outside of the plan.

5 There's some language that treats
6 the idea that people should be properly reviewed,
7 they should be heard, they should have the right
8 to appeal, but the language of the statute
9 actually states specifically that the rules shall
10 alter criteria to allow you to seek a provider
11 outside your employer's plan and there's no such
12 criteria set forth in this rule.

13 The third point, I've labelled it to
14 be on page 4, which would be the "Application
15 Process." I was looking there in terms
16 of -- under A on subdivision 5, it talks about the
17 name and address of the medical director, but it
18 goes on to talk about that the medical director
19 shall be an M.D. physician, which I think is
20 probably odd that it's not osteopathic, it's all
21 M.D. physicians.

22 We would just suggest that the

1 language ought to be that the medical director of
2 these managed care plans could well be a
3 physician, a licensed physician status provider
4 within the definition of Workers' Compensation and
5 that that person should be licensed by the state
6 of West Virginia.

7 That's not anywhere in the provision
8 and we think that to make that just an M.D.
9 specific requirement would actually maybe
10 disqualify people that already work for the fund
11 that are osteopaths, assuming some day they may
12 want to be a medical director.

13 My last comment puts us on page 4,
14 is about the provisions on page 7, "Other
15 Administrative Provisions." On page 7, you will
16 find that provision to be under 9.1, that talks
17 about report of injuries and this just is a
18 technical thing that goes to executing labors,
19 since to be treated or release records.

20 We don't see any reason there should
21 be a distinction between physician patient,
22 psychiatrist patient and chiropractic patient

1 privileges.

2 The fund has already determined that
3 physician status providers are chiropractors,
4 medical doctors and osteopaths and it's already
5 established and we keep finding rules that have
6 these distinctions in it.

7 Of course, being a two decade
8 guardian of the chiropractic law, I try to clear
9 up inconsistencies in these rules.

10 When I get people writing rules that
11 say chiropractic this, chiropractic that and they
12 are just again trying to take away pieces of what
13 over the years have been protected as doctors who
14 have many hours of post-graduate studies, who are
15 regulated by a fine board and who provide great
16 services to their patients and who provide cost
17 effective services, they just need to be treated
18 on equal footing with regard to the rights they
19 have already established in Workers' Compensation.

20 I'll leave you with a final comment,
21 which is maybe just reiterating my point. We
22 understand the inevitability of moving toward

1 managed care and how it's been moved through
2 throughout the health care industry.

3 We are probably more experienced in
4 handling complaints and problems of managed care
5 organizations than probably any other provider
6 organization. But I will tell you that as we move
7 to companies who have never offered a chiropractic
8 benefit under ERISA because they could exempt it
9 out, and we try to incorporate those into a
10 Workers' Compensation plan that provides a
11 chiropractic benefit, we would hope to have your
12 help and agreement to come back and work with the
13 Commission and protect the chiropractic profession
14 in the state from not just getting into a big
15 technical snafu that suddenly they just don't
16 exist as a profession because the health care
17 plans didn't authorize them to start with.

18 At that, I would take any questions
19 you might have and I appreciate you listening to
20 my comments.

21 CHAIRMAN WHITE: Thank you very much,
22 Mr. Stowers. Any questions of Mr. Stowers? Any

WEST VIRGINIA WORKERS' COMPENSATION BOARD OF MANAGERS
PUBLIC HEARING
OCTOBER 26, 2004 - 1:00 P.M.
85CSR21 "MANAGED HEALTH CARE PLANS"

ATTENDANCE SHEET

The Board is required to keep a list of individuals attending its meetings and of those who wish to address the Board.

NAME	COMPANY	Do you wish To speak? (Yes/No)
Sheryl Demme	WV WEG	
Darryl Kennedy	Nobody	No
Barbara Spradling	WV. Comp	No
Garr Shorter	YMOST	no
Cathy Eppelhart	GARDIN	NO
Roger Triche	Stephoe & Johnson	No
Susan Osborne	AMWEST	No

WEST VIRGINIA WORKERS' COMPENSATION BOARD OF MANAGERS
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ATTENDANCE SHEET

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NAME	COMPANY	Do you wish to speak? (Yes/No)
Phillip m. Stowers	West Va Chiropractic Soc Inc	Yes
Lynn Hampton	UMT	No
Tessa McCallister	CMTI	No

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REPORTER'S CERTIFICATE

STATE OF WEST VIRGINIA,
COUNTY OF KANAWHA, to wit:

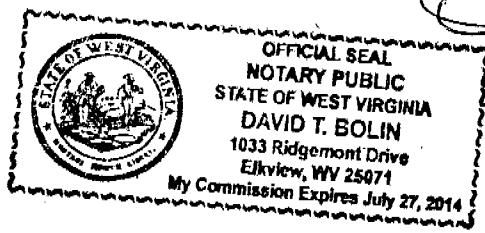
I, the undersigned, David T. Bolin,
Courter Reporter and Notary Public, do hereby
certify that the foregoing is, to the best of my
skill and ability, a true and accurate transcript
of the proceedings had before the **West Virginia
Workers' Compensation Board of Managers** as set
forth in the caption hereof, and that this is the
original transcript thereof for the files of the
Committee.

GIVEN UNDER MY HAND THIS 2nd
DAY OF NOVEMBER, 2004.

MY COMMISSION EXPIRES JULY, 2014.



Court Reporter



October 26, 2004

T. J. Obrokta, General Counsel
Executive Office
Workers' Compensation Commission
4700 MacCorkle Avenue, S.E.
Charleston, West Virginia 25304

Re: Series 21
Managed Health Care Plans

Dear Mr. Obrokta:

Please consider these public comments related to the proposed rule which repeals and replaces the current Series 21, 85 C.S.R. 21 of the Workers' Compensation Rules.

We strongly support the creation of a managed health care plan option and believe the implementation of this rule could have a significant positive impact upon the workers' compensation system for employers and employees.

COMMENT 1: § 85-21-5.1.b.2 on page 5 of the proposed rule requires "a professional malpractice policy with limits of no less than \$1,000,000 for an occurrence of professional negligence" for all "participating providers" in a managed health care plan. A "managed health care plan" is defined in § 85-21-3.6 to include a network of "health care providers".

If the definition of health care providers is to be strictly construed to include only medical vendors in the employers' managed health care plans, the malpractice policy occurrence minimum appears appropriate. However, if it is contemplated that the networks can be more comprehensively defined to include vocational rehabilitation providers, the per occurrence language for professional negligence may need to be amended as recommended by experts in that area.

COMMENT 2: § 85-21-8.2 on page 7 of the proposed rule states that should the Commission "believe" grounds exist for terminating or suspending a managed health care plan, a notice is mailed and the plan is given only fifteen (15) days from the date of the notice to respond. Thus, given the time for receipt of the mail, the plan has less than fifteen (15) days to respond. In addition, some plans may receive a significant amount of mail each day which is opened and sorted by staff, and the significance of the notice may not even be recognized on the day received.

T. J. Obrokta, General Counsel
October 26, 2004
Page 2

The investment required by plans and employers and the potential for the interruption of critical health care to employees require due process prior to the termination of a plan. This requirement is particularly important given that the standard for suspension or termination of the plan by the Commission includes "any good faith basis as determined in the sole discretion of the Commission" pursuant to § 85-21-8.1.e.

We recommend that any notice of suspension or termination be provided to the plan by certified mail, with the written response due fifteen (15) days from the date of the verified receipt. In addition, although suspension may be ordered by the Commission upon a careful review of the plan's written response, that suspension should take place only if the Commission's own managed health care plan agrees to provide health care to the plan participants immediately. In addition, the suspended plan should be afforded an expedited hearing and a final decision by the Office of Judges within thirty (30) days of the date of the notice of suspension prior to any termination of the plan. In the absence of a right of further appeal, we also recommend that any employer whose plan is terminated be provided with the opportunity to submit a new application for approval.

Recommended alternate language for § 85-21-8.2:

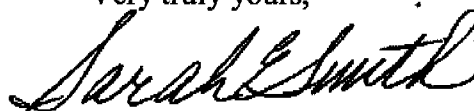
8.2. The Commission may investigate the operations of a certified managed health care plan at any time and the plan and its providers shall cooperate in any investigation by the Commission. Should the Commission ~~believe~~ find that reasonable grounds for termination or suspension of a managed care plan certification exist, written notice setting forth those grounds shall be mailed to the system by certified mail, return receipt requested. The system is granted fifteen (15) days from the date of the verified receipt of the notice in which to file a written response. Thereafter, the Commission shall render a written decision by which the certification of the plan may be terminated, suspended, or conditionally continued to permit the correction of deficiencies directed. If suspended, the plan shall be afforded a hearing and a final decision by the Office of Judges reinstating or terminating the plan within thirty (30) days of the date of the notice of suspension, which The Commission's decision is final and unappealable. The receipt of a suspension or termination shall not preclude a new application for approval of the plan to the Commission pursuant to § 85-21-4.

COMMENT 3: We agree with the language of § 85-21-9 which makes it clear that medical release authorizations shall be executed related to "any condition or complaint reasonably related to the condition for which the employee claims compensation." We have attached a recommended release for approval by the Commission and adoption as a form which will eliminate amended, improper, or overly narrow releases that do not permit the review and disclosure of relevant medical history.

T. J. Obrokta, General Counsel
October 26, 2004
Page 3

Thank you for considering these comments.

Very truly yours,



Sarah E. Smith

SES/pl

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

I. Class of Persons Authorized to Make the Requested Disclosure: I hereby authorize any physician, hospital, medical facility, insurance company, health care provider or any other person, individual or entity that has furnished medical treatment, given medical advice, and/or possesses medical records or documents pertaining to my medical history or treatment, including psychiatric or mental health treatment to release such records to _____ or their agents or representatives for use in one or more workers' compensation claims filed.

II. Persons or Class of Persons to Whom Disclosure May Be Made: The disclosure permitted by this Authorization may be made to _____, at **[ADDRESS]**.

III. Description of Information to be Disclosed. I authorize the release and disclosure of any and all medical records, histories, reports, original radiological films or imaging and pathology materials, and information pertaining to me, of whatever kind and character and including but not limited to psychiatric, psychological or mental health records from **[DATE OF BIRTH]**, to the present, to the persons identified in Section II of this Authorization.

IV. Purpose of Disclosure. The authorized disclosure is for use in one or more workers' compensation claims which I have filed in the State of West Virginia.

V. Expiration Date. This Authorization shall remain valid until the later of either two (2) years from the date of its execution or the conclusion of my workers' compensation claims, unless sooner revoked by me, in writing, as provided for in Section VI.

VI. Right to Revoke. I understand that I have the right to revoke this authorization at any time by notifying _____ in writing at **[ADDRESS]**. I understand that the revocation is only effective fifteen (15) days after receipt by _____. I understand that any use or disclosure made prior to the effective revocation under this authorization will not be affected by a revocation.

VII. No Conditions Imposed; Right to Copy of Authorization. I understand that my treatment by the person/organization being authorized to disclose my health information will not be conditioned upon my willingness to sign this authorization, that I am entitled to receive a copy of this authorization upon written request, and that a photocopy of this authorization shall have the same force and effect as the original.

VIII. Possible Redisclosure. I understand that after this information is disclosed, federal law might not protect it and the recipient might re-disclose it to others, including the Workers' Compensation Commission, Workers' Compensation Office of Judges, Workers' Compensation Board of Review, West Virginia Supreme Court of Appeals, or other physicians, experts or consultants pursuant to my workers' compensation claims.

This authorization is intended to be compliant with and is a valid waiver of the privacy rule contained in the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Claimant _____ Date: _____

Social Security No.: _____ Witness _____

Date of Birth: _____

Telephone
304-344-3300
Facsimile
304-344-3357

STOWERS & ASSOCIATES

ATTORNEYS AT LAW
405 Capitol Street, Suite 806
P.O. Box 786
Charleston, WV 25323

*Phillip M. Stowers, Esq.
David Schles, Esq.

October 26, 2004

Mr. T. J. O'Broakta, Jr.
General Counsel
WV Workers' Compensation Division
4700 MacCorkle Avenue
Charleston, WV 25304

RE: Managed Health Care Plans Rule Series 21

WRITTEN COMMENTS ON BEHALF OF THE WEST VIRGINIA CHIROPRACTIC SOCIETY INC.

With regard to Workers' Compensation proposed rule series 21 Managed Health Care Plans, the West Virginia Chiropractic Society Inc., submits the following recommendations and comments:

1. On page 1 §85-21-4.1.b striking the ";" at the end of the sentence and inserting the following: "and the plan shall demonstrate that it includes sufficient numbers of each type of licensed medical provider that is approved to provide medical services by the commission;"

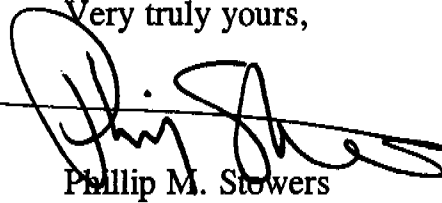
This is an important provision to guarantee that an approved managed care plan shall have within its panel sufficient types of medical providers available to provide the medical coverages authorized by statute.

2. On page 2 §85-21-4. Minimum Plan Standards.
There exists no provision in this rule to satisfy West Virginia Code §23-4-3(b)(2). This statutory provision requires the commission to adopt criteria providing a mechanism for a claimant to request and receive written approval to seek a health care outside the employer's plan. The rule should be amended to meet the statutory requirement.
3. On page 4 §85-21-5 Application Process.
Specifically in provision 5.1.a.5 name and address of medical director. Under this language a doctor such as Dr. Short with the Workers' Compensation Commission would not be qualified as a medical director. This provision should require a medical director to be licensed as a physician status provider within the definition of the Workers' Compensation Commission and that the director should be licensed by the state of West Virginia.

4. On page 7 §85-21-9.1 Other Administrative Provisions.
There appears to be no reason for the distinction between physician - patient, psychiatrist - patient and chiropractic - patient privileges. The section should be written to reflect physicians pursuant to Chapter 30 of the code.

We appreciate the opportunity to submit these comments. Should you have any questions please do not hesitate to give me a call.

Very truly yours,

A handwritten signature in black ink, appearing to read "Phillip M. Stowers", is written over a horizontal line. The signature is stylized and cursive.

Phillip M. Stowers

Response to Public Comments
Rule 21 – Managed Health Care Plans

Sally Smith

1. Section 5.1.b.2 insert “, unless the Commission determines, in its sole discretion, that a different malpractice limit is more appropriate given the providers’ specialty or discipline.”

Response: Accept to clarify that the malpractice limit is not intended to extend to providers such as vocational rehabilitation providers who may not need such a large malpractice policy.

2. Section 8.2: Make certain modification to the notice of a suspension/termination process by 1) inserting “a” between “of” and “certified” on the first line; 2) striking “believe” and inserting “find” on the third line; 3) insert “reasonable” before “grounds” on the third line; 4) inserting “by certified mail, return receipt requested” at the end of the second sentence; and 5) inserting “verified receipt of the notice” between “the” and “notice” on the fifth line.

Response: Accept, with the clarification added to the 5th comment that the time limit also runs from the date of refusal of the notice.

3. Make a suspension or termination of a managed health care plan appealable to the Office of Judges and otherwise subject to the litigation process.

Response: Reject.

4. Attached a recommended release to be approved and adopted as a form.

Response: The Commission will determine whether the proposed release is something it will use and will not incorporate the release into the rule itself.

Phillip M. Stowers

1. Section 4.1.b: Insert language requiring that each proposed plan contain a sufficient number of all licensed medical providers.

Response: Reject. If a plan does not provide for a certain service or specialty, then the injured worker may show good cause to “opt out” and seek treatment from any provider offering such services. As such, the proposed language is unnecessary and would require the Commission to micromanage the managed health care plans.

2. Section 4. Insert language to allow for opting out of the plan.

Response: The is already exists in Section 13 of the proposed rule

3. Section 5.1.a.5.: Expand who can be a medical director of a plan to include all “physician status providers within the definition of the Workers’ Compensation Commission.”

Response: Insert “or D.O.” after “physician” in the parenthetical.

4. Section 9: Avoid the Physician/patient, psychiatrist/patient and chiropractic/patient privileges.

Response: Accept by striking “physician-patient, psychiatrist-patient, or chiropractic-patient.”

Will Brotherton

1. Section 4.1 Insert “or others” to allow TPA’s to submit plans

Response: Accept comment with clarification to limit suggestion to TPAs and not all others.

2. Section 4.1.h. Strike “in the applicable fee schedule” and insert “by the particular plan” to allow plans to pay above the fee schedule

Response: Accept.

3. Insert a New Section 4.2: “This Rule shall not preclude or otherwise limit an injured workers’ right to seek care from a provider outside the approved plan or approved opt-out provider at his or her own expense.”

Response: Accept.

Board of Managers

1. Section 4.1.c: Insert “driving” between “75” and “miles”

Response: Accept.

2. Section 10.2: Insert “minimum” between “following” and “requirements.”

Response: Accept.

SUPPLEMENTAL RULE 21 AMENDMENT

1. West Virginia Chiropractic Society

In response to a recent comment received from the West Virginia Chiropractic Society, the following amendment is offered to Rule 21:

New 13.2: Injured workers may access providers who are not participating plan providers for treatment purposes only if the injured worker has established by competent evidence all of the following:

1. The injured worker has been treated by providers solely within the employer's managed care plan for a period of at least one (1) year;
2. That for reasons related to the treatment alone, the injured worker has not made progress toward recovery that is reasonably consistent with the Commission's treatment guidelines;
3. That the injured worker establishes to a reasonable certainty that proposed treatment outside the employer's managed care plan would more likely provide the injured worker with a better clinical outcome than the current treatment or rehabilitation plan; and
4. A condition of the right to opt out under this provision shall be that the services secured outside the plan are for treatment purposes only and the provider shall not be permitted to rate the injured worker for permanent partial or permanent total disability. Any provider providing services pursuant to this provision shall be barred from providing such a rating.

2. Commission

The Commission proposes the following amendment to Section 11.1:

Insert "semi-" before the word "annual."