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**STATEMENT OF POLICY**

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**TITLE 34: LABOR AND INDUSTRY**

**PART VIII: BUREAU OF WORKERS' COMPENSATION**

**CHAPTER 122. GENERAL PROVISIONS OF ACT 57 OF 1996 – STATEMENT OF POLICY**

**SUBCHAPTER A. [RESERVED]**

§§ 122.1 - 122.11. [Reserved]

**SUBCHAPTER B. [RESERVED]**

§§ 122.101 - 122.104. [Reserved]

**SUBCHAPTER C. [RESERVED]**

§§ 122.201 and 122.202. [Reserved]

**SUBCHAPTER D. [RESERVED]**

§§ 122.301 - 122.303. [Reserved]

**SUBCHAPTER E. [RESERVED]**

§ 122.401. [Reserved]

**SUBCHAPTER F. [RESERVED]**

§§ 122.501 and 122.502. [Reserved]

**SUBCHAPTER G. COORDINATED CARE ORGANIZATIONS – STATEMENT OF POLICY**

**§ 122.601. Applicability and purpose**

(a) This subchapter provides information to employers, workers' compensation insurers, providers, provider organizations and injured workers concerning how the Department proposes to exercise its authority under the act to certify and monitor CCOs. The information will enable potential applicants for certification to commence the application process. This subchapter is not, and does not purport to be, a regulation. It does not, therefore, have the force of law. Rather, it expresses the present intentions of the Department with respect to implementing the certification program.

(b) This subchapter should be reviewed by persons who undertake to establish, operate and maintain a CCO.

**§ 122.602. Definitions**

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

*Act*—The Workers' Compensation Act (77 P. S. §§ 1—1031).

*Adequate access*—A reasonable distance an injured worker must travel to secure primary medical services through a CCO, generally not greater than a 30-minute non-rush hour drive from the worker's home or place of employment, whichever is the more appropriate point.

*Bureau*—The Bureau of Health Care Financing of the Department.

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## STATEMENT OF POLICY

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*CCO—Coordinated Care Organization*—An organization licensed in this Commonwealth and certified by the Department to provide medical services to an injured worker after it demonstrates that it has met the criteria for certification as a CCO established by section 306(f.2) of the act (77 P. S. § 531.1).

*Case management*—A collaborative process, system or service which assesses, plans, supports, implements, coordinates, monitors and evaluates options and services to meet an injured worker's health needs through communication and available resources to promote quality cost-effective outcomes, and which deals primarily with the social, personal and economic factors relevant to a worker's injury, but which does not include the actual provision of medical care, treatment or services.

*Department*—The Department of Health of the Commonwealth.

*Injured worker*—A worker or employe entitled to or claiming compensation or medical benefits under or covered by the act.

*Organization licensed in this Commonwealth*—A single entity—that is, a partnership, corporation, and the like—which is authorized to do business in this Commonwealth and which has a clearly identifiable and unified administrative and functional structure as determined by the Department.

*Participating coordinated care provider*—A provider who is employed by a CCO or a CCO affiliate or who has entered into an agreement or contract with a CCO, and who provides treatment, accommodations, products or health services to injured workers pursuant to that relationship.

*Primary medical services*—The following services frequently utilized by injured workers:

- (i) Inpatient hospital medical surgical services.
- (ii) Hospital emergency room or urgent care center services.
- (iii) Primary care physician—family practitioner or general internal medicine—services.
- (iv) Diagnostic imaging facility services.
- (v) Inpatient and outpatient physical therapy and rehabilitation services.
- (vi) Rehabilitation medicine specialist services.
- (vii) Orthopedic specialist services.
- (viii) General surgery specialist services.
- (ix) Ophthalmology specialist services.
- (x) Chiropractic services.
- (xi) Neurological specialist services.
- (xii) Mental health professional services.

*Single service referral, provider participation and payment agreement*—A combined referral form and provider agreement utilized by a CCO to refer an injured worker to a provider who has not entered into a general contract or agreement with the CCO to treat the injured workers referred by the CCO.

### § 122.603. Uncertified CCOs

- (a) An individual, partnership, corporation or other entity may not operate or maintain a CCO unless it has been certified as a CCO by the Department.
- (b) In determining whether an entity requires certification as a CCO, the Department will consider whether it engages in any of the activities described in or required by §§ 122.609—122.613 and 122.615.
- (c) The Department will not consider an entity which engages in activity limited to case management to require certification as a CCO if the entity does not hold itself out as or operate as a CCO.

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## STATEMENT OF POLICY

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### § 122.604. Application process

- (a) An applicant for certification as a CCO shall submit the following to the Bureau:
  - (1) Two copies of a completed application form, available from the Bureau, Room 1026 Health and Welfare Building, Post Office Box 90, Harrisburg, Pennsylvania 17108-0900.
  - (2) Two copies of written documentation to supplement its application and establish that it meets the requirements in the act and this subchapter.
  - (3) A certified check in payment of the application fee as established by regulation.
- (b) The Department will consider an application to be incomplete if the submissions fail to conform with subsection (a) or do not reflect a good faith attempt by the applicant to provide a detailed and credible response to each question and include adequate and appropriate documentation when required.
- (c) When the Department finds an application to be incomplete, makes a preliminary determination that the documentation submitted is inadequate to demonstrate that the applicant has met the requirements for certification or has questions about or needs clarification of an element of the application, the Department will send a letter to the applicant advising it of the inadequacies and requesting additional information or documentation, as appropriate.
- (d) The Department will review complete applications on a first received-first reviewed basis, based upon the date and time each application is date-stamped as having been received by the Bureau. When an incomplete application is made complete through subsequent filings, it will be placed last on the list for reviewing complete applications.

### § 122.605. Certification application fees

- (a) The Department will establish a certification application fee by regulation. The regulation will establish the procedures and requirements for paying this fee.
- (b) The Department anticipates that the application fee will be approximately \$1,500. The Department also anticipates that it will bill persons for the fee if they applied prior to the effective date of the regulation, and that issuance of an initial certificate or a renewal certificate may be conditioned upon payment of the fee.

### § 122.606. Certification periods

A certificate will be valid for 2 years from the date of its issue, unless the certificate is earlier suspended or revoked by the Department for failure of the CCO to meet the provisions of section 306(f.2)(4) of the act (77 P. S. § 531.1(4)) or applicable regulations.

### § 122.607. Recertification

- (a) A CCO shall apply for recertification as a CCO no later than 120 days prior to the expiration date of its certification.
- (b) The Department will establish a fee to apply for recertification by regulation. The Department anticipates that the fee will be approximately \$1,500.
- (c) An application for recertification shall include information the Department may require to demonstrate that the CCO has been operating and will continue to operate in accordance with the act and this subchapter.
- (d) A CCO applying for recertification shall also include the following in its recertification application:

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## STATEMENT OF POLICY

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- (1) A detailed report of the status of the completion of its quality assurance work plan, as set forth in the initial application for certification or subsequent application for recertification.
- (2) A summary of the results of the injured worker satisfaction surveys.
- (3) A summary of changes, and documentation relevant to those changes as required by § 122.608 (relating to contents of an application for certification as a CCO), if the information or documentation which was required for CCO certification under § 122.608 has changed since the most recent application and has not been previously reported to or approved by the Department.

### **§ 122.608. Contents of an application for certification as a CCO**

An application for certification as a CCO shall include the following:

- (1) Ownership information, including the following:
  - (i) A disclosure of whether the applicant is owned or controlled, directly or indirectly, by a self-insured employer or a workers' compensation insurer.
  - (ii) A list of the owners of the proposed CCO with a 5% or greater ownership interested.
  - (iii) A chart of the relationship between the proposed CCO, its parent and other subsidiaries of the parent corporation, if the proposed CCO is a subsidiary or affiliate of another corporation.
- (2) An organization chart listing reporting relationships and the positions supporting the operations of the CCO, particularly in the areas of utilization review, quality assurance, case management and communication and provider relations. An addendum to the chart shall describe how increased utilization of CCO services will affect staffing and staffing to injured worker ratios.
- (3) A description of the geographic service area by county in which the CCO proposes to operate. The description shall demonstrate how the applicant will comply with § 122.609 (relating to requirements for a CCO's health service delivery system).
- (4) A complete list of participating coordinated care providers:
  - (i) Identifying whether the provider is an employe or affiliate of or has entered into a contract or agreement with the CCO.
  - (ii) Identifying the geographic area—usually county—in which each provider practices and its specialty.
  - (iii) Explaining how the CCO's contractual arrangements with providers meet the requirements of § 122.610 (relating to standards for contracts and agreements with providers).
- (5) A map of the proposed service area indicating the location of participating coordinated care providers.
- (6) A copy of the generic contract the applicant will utilize to contract with workers' compensation insurers and self-insured employers to offer its services and negotiate provider rates of payment.
- (7) A copy of literature in draft or final form that the applicant will utilize to market its services to workers' compensation insurers, self-insured employers and injured workers, and a copy of injured worker literature which meets the requirements of § 122.625 (relating to injured worker literature). If final-form literature is not available for submission with the application and the applicant meets the other standards, the Department will conditionally certify the applicant as a CCO if it has provided draft literature, conditioned upon its submission of literature in final form within 60 days of approval. The Department will withdraw the conditional certification if the final-form literature is not submitted to it within the 60 days or if the literature is not satisfactory to the Department.

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## STATEMENT OF POLICY

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- (8) A description of the manner in which an injured worker initially selecting the CCO shall gain access to treatment by a participating coordinated care provider. This document shall meet the requirements of § 122.609.
- (9) A copy of generic form contracts, or letters of agreement, and compliance riders used by the applicant to contract with participating coordinated care providers. These documents shall meet the requirements of § 122.610.
- (10) A description of how the applicant's case management and evaluation system meets the requirements of § 122.611(a) (relating to standards for a case management and evaluation system and case communication system), and a copy of the written record required by § 122.611(a)(1).
- (11) A description of the applicant's case communication system which demonstrates how the applicant meets the standards of § 122.611(c).
- (12) A description of the applicant's utilization review system which demonstrates how the applicant meets the standards of § 122.612 (relating to standards for utilization review), and a copy of the documentation specified in § 122.612(a)(6)(i).
- (13) A description of the applicant's quality assurance system which demonstrates how the applicant meets the standards of § 122.613 (relating to standards for quality assurance program), and a copy of the documentation specified in § 122.613(2), (5) and (6).
- (14) A description of the applicant's written grievance system which demonstrates how the applicant meets the standards of § 122.615 (relating to injured worker grievance system and provision of alternatives), and a copy of the documentation specified in § 122.615(g).
- (15) If the applicant seeks exemption of a provision in section 306(f.2)(2) and (3) of the act (77 P. S. § 531.1(2) and (3)), the specific requirements from which it seeks exemption and the justification for the applicant's inability to meet the requirements.
- (16) A description of the injured worker satisfaction survey process the applicant will utilize to survey injured workers who have been treated by the CCO which demonstrates how the applicant meets the standards of § 122.614 (relating to injured worker satisfaction program).
- (17) A copy of the proposed single service referral, provider participation and payment agreement, if any, to be utilized by the applicant to coordinate and manage referrals, which demonstrates how the applicant meets the standards of § 122.609(c)(2).
- (18) A copy of the policy face sheet or other evidence that the applicant has medical malpractice liability insurance or errors and omissions liability insurance, as appropriate, for the liability risks assumed by the applicant.
- (19) A copy of a contract with an independent organization from which the applicant chooses to purchase case management and communication or utilization review services, if it chooses not to provide the services directly through its own employed staff or the staff of an affiliate/subsidiary, which demonstrates how the applicant meets the requirements of § 122.626 (relating to contracts with independent organizations for performance of case management and communication or utilization review services).

### **§ 122.609. Requirements for a CCO's health service delivery system**

- (a) An applicant, to be certified or recertified, and a CCO to maintain a CCO certification, shall have the following:

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## STATEMENT OF POLICY

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- (1) An adequate number and specialty distribution of licensed participating coordinated care providers to provide primary and other medical services to injured workers.
  - (2) The capacity to provide all primary medical services to injured workers.
  - (3) The establishment and maintenance of referral capacity to treat other injuries and illnesses.
  - (4) A system which provides timely delivery of health care services to the injured worker.
- (b) To establish that it meets the standards in subsection (a)(1) and (2), an applicant for certification or recertification as a CCO shall present evidence that it employs, owns or has acceptable provider contracts or agreements with a sufficient number and distribution of providers within a reasonably defined service area within which an injured worker shall have adequate access to primary medical services.
- (c) To establish that it meets the standards in subsection (a)(3), an applicant for certification or recertification as a CCO shall demonstrate that it has written procedures to do at least one of the following:
- (1) Enter into an agreement with the provider to whom the injured worker is to be referred by which the provider agrees to treat the injured workers referred by the CCO. The agreement shall meet the requirements of § 122.610 (relating to standards for contracts and agreements with providers).
  - (2) Enter into an agreement with the provider to whom the injured worker is to be referred, when a referral becomes necessary, by which the provider agrees to treat the specific injured worker being referred. The agreement which may be referred to as a single service, provider referral, participation and payment agreement, shall be subject to approval by the Department, but because of its limited nature, need meet only the following requirements instead of the requirements of § 122.610. The agreement shall:
    - (i) Contain identification of the CCO initiating the referral, the injured worker being referred, the referral services requested and the payor source—workers' compensation insurer or self-insured employer.
    - (ii) Include a provision asserting that by signing the form and submitting a bill to the payor, the provider accepting the referral agrees to limited participation in the CCO for the named injured worker only.
    - (iii) Include a provision by which the provider to whom the injured worker is to be referred agrees to cooperate with the CCO's case management, utilization review and quality assurance systems as applied to the care provided the named individual injured worker, and agrees to abide by the decisions of these CCO systems.
    - (iv) Include a provision by which the provider to whom the injured worker is to be referred agrees to accept the fee level negotiated by the CCO as payment in full for services it provides the injured worker which are covered under the act.
    - (v) Include a provision by which the provider to whom the injured worker is to be referred agrees to provide the CCO and the Department access to the injured worker's medical records.
    - (vi) Include a provision asserting that the provider to whom the injured worker is to be referred accepts that the injured worker's signature on the referral form constitutes permission to release the injured worker's medical records regarding treatment by that provider to the CCO and the Department.
- (d) To establish that it meets the standards for timely delivery of health care services in subsection (a)(4), an applicant for a CCO certification or recertification shall present evidence in the form of written policies

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## STATEMENT OF POLICY

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and procedures, provider contract or agreement requirements or otherwise, which demonstrates that the CCO health service delivery system will meet and continue to meet the following conditions:

- (1) Medically necessary urgent care shall be provided within 24 hours of the request for the care by the injured worker or another person, on the injured worker's behalf, if the injured worker is incapable of making the request.
- (2) If referral for specialty care is required, the referral shall occur within 48 hours of the identification of the need for the specialty care and the specialty care shall be provided or arranged for within 96 hours of identification of the need for specialty care.
- (3) Nonurgent care shall be provided or arranged for within seven days of the request for the care.

### **§ 122.610. Standards for contracts and agreements with providers**

(a) A contract or agreement between a CCO and a participating coordinated care provider, unless the provider is employed by the CCO or is an affiliate/subsidiary of the CCO, shall contain the following minimum provisions necessary to enable the CCO to coordinate and manage care in a high quality manner and protect injured workers:

- (1) A provision requiring the participating coordinated care provider to accept the CCO reimbursement schedule as payment in full for services covered by the act which are rendered to an injured worker.
- (2) A provision prohibiting the participating coordinated care provider from collecting or attempting to collect from an injured worker payment for treatment or service provided by the provider and determined by the CCO not to be medically necessary or in accordance with clinical protocols established by the CCO. The provision shall likewise prohibit the participating coordinated care provider from collecting or attempting to collect from an injured worker a financial penalty imposed upon the provider for failure to abide by the CCO's precertification or other utilization review or case management requirements.
- (3) A provision requiring the participating coordinated care provider to abide by the CCO's standards for medical records and to provide medical record access to the CCO and the Department or an external quality review organization approved by the Department and selected by the CCO or the Department to review the quality of care being provided by the CCO.
- (4) A provision requiring the participating coordinated care provider to participate in and abide by the decisions of the CCO's quality assurance, utilization review and injured worker grievance systems.
- (5) A provision requiring the participating coordinated care provider to abide by the internal rules, regulations and guidelines of the CCO regarding referrals, case management, case communication, data reporting requirements and other matters affecting the internal administration of the CCO's delivery system.
- (6) A provision requiring the participating coordinated care provider to promptly report to the CCO a change in its status under the CCO's credentialing requirements, including loss or diminishment of hospital privileges and loss or restriction of license.
- (7) A provision requiring the participating coordinated care provider to provide or arrange for the provision of medically necessary services as required by § 122.609 (relating to requirements for a CCO's health service delivery system).
- (8) A provision requiring the participating coordinated care provider to accept referrals from the CCO or other participating coordinated care providers within the CCO network, and whenever possible and medically appropriate, to refer injured workers to participating coordinated care providers within the CCO network within the time frames and in accordance with other standards in § 122.609.

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## STATEMENT OF POLICY

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- (9) A provision setting forth the circumstances under which a participating coordinated care provider may discontinue treatment of or refuse treatment to an injured worker with whom the provider has failed to establish a provider-patient relationship and requiring the referral of the injured worker to another appropriate provider within the time frames in § 122.609(d).
- (10) A provision requiring that no change in the provider contract or agreement shall be effective, except for changes required by the Department, without 30 days advance notice and the opportunity to cease participation in the CCO if the changes are unacceptable to the participating coordinated care provider.
- (11) A provision requiring the participating coordinated care provider to abide by the CCO's and the Department's confidentiality requirements.
- (12) A provision specifying the contract or agreement termination rights and termination notice requirements for both the CCO and the participating coordinated care provider. Both the CCO and the participating coordinated care provider shall have the right to terminate the contract or agreement with no more than 60 days advance notice.
- (b) A CCO that delivers services in whole or part through employed providers shall impose upon the employees the same requirements it is required to impose on contracted providers in subsection (a).
- (c) An applicant for a CCO certification, which has existing provider contracts, may meet the requirements of subsection (a) through an appropriate provider contract rider, which shall be submitted as part of its application.
- (d) Information relating to a CCO's reimbursement rates, which is received by the Department under this section, shall be confidential, except that the Department may use the data, without identification of a particular provider, as part of the Department's efforts to provide statistical reports on the operation of CCOs under the act.

### **§ 122.611. Standards for a case management and evaluation system and case communication system**

- (a) A CCO shall establish, operate and maintain a case management and evaluation system which includes continuous monitoring of treatment from onset of the injured worker's injury or illness until the injured worker leaves the care of the CCO, and which meets the following standards. The system shall:
- (1) Maintain a written record of staffing of its case management and evaluation system, the professional expertise of the staff and staffing to injured worker ratios.
  - (2) Be staffed by an adequate number of trained and experienced registered nurses and rehabilitation specialists who are trained and experienced in workers' compensation or disability management and supervised by appropriate clinicians.
  - (3) Monitor an injured worker's progress through appropriate daily or weekly contact with the injured worker and persons providing health services to the injured worker.
  - (4) Assist the injured worker, the worker's family and participating coordinated care providers treating the worker to develop appropriate treatment plans and make referrals within the CCO network.
  - (5) Work with participating coordinated care providers and injured workers to develop treatment and discharge plans, work-hardening programs and physical, occupational and vocational rehabilitation therapy.
  - (6) Coordinate return to work plans with employers and recommend part-time or light duty work plans.
  - (7) Identify an injured worker's abilities and skills and match them with work opportunities.

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## STATEMENT OF POLICY

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- (8) Prohibit the implementation of a treatment plan and referral under paragraph (4), and prohibit the implementation of another implement plan under paragraphs (5) and (6), without securing the injured worker's consent.
- (b) A CCO may combine its utilization review and case management functions and departments.
- (c) A CCO shall establish, operate and maintain a case communication system which periodically relates necessary and appropriate information concerning the injured worker, as required by the act, among the injured worker, the injured worker's employer, health care providers and the employer's workers' compensation insurer. Dissemination of this information shall be solely for the purpose of providing treatment to or coordinating care for the injured worker.
- (d) The CCO shall be prohibited and shall prohibit its providers, employes or agents who may obtain, be provided with or acquire information as a result of the CCO's treatment of an injured worker, from releasing the information to another person without the consent of the injured worker, except as required by the act or regulations.

### **§ 122.612. Standards for utilization review**

- (a) A CCO shall have an organized system for the review of the utilization of services rendered by the CCO and its participating coordinated care providers to injured workers to avoid the provision of poor quality care to injured workers which may arise from either underutilization or overutilization of services. A CCO may engage in prospective, concurrent or retrospective review without obtaining a separate approval from the Department of Labor and Industry as a utilization review organization, subject to the following conditions:
- (1) The CCO shall place responsibility for compliance with utilization review requirements, particularly precertification requirements, upon its participating coordinated care providers and not upon injured workers.
  - (2) The CCO shall prohibit participating coordinated care providers from collecting payment from injured workers for care provided by the provider but rejected for payment by the CCO and the payor as being medically unnecessary, or for a financial penalty or fee reduction imposed on the provider due to its failure to follow CCO precertification requirements.
  - (3) The CCO shall conduct utilization review on treatment provided to an injured worker only for the 30-day period it is entrusted with treatment of the injured worker by virtue of the injured worker having initially selected the CCO from the health care provider list offered by the employer under section 306(f.1)(1)(i) of the act (77 P. S. § 531.1(1)(i)), and during the time that the injured worker continues to utilize the CCO for treatment of the work-related injury.
  - (4) The CCO shall have an adequate procedure for a participating coordinated care provider dissatisfied with the initial utilization review decision to appeal that decision. An injured worker dissatisfied with an initial utilization review decision shall have the right to appeal that decision through the grievance process.
  - (5) The CCO shall make decisions regarding pretreatment certification and appeals from utilization review decisions within 7 days of the request and provide notice of its decision to the provider and injured worker.
  - (6) The CCO shall do the following:
    - (i) Maintain a written record of staffing within its utilization review system; the professional experience of the staff; staffing to injured worker ratios; and the basis and source of the criteria, standards and guidelines the CCO uses in conducting utilization and return to work case management review.

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## STATEMENT OF POLICY

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- (ii) Disclose to its participating coordinated care providers its utilization review criteria, standards and guidelines.
  - (iii) Make available its utilization review criteria, standards and guidelines to injured workers utilizing the CCO, their employers and workers' compensation insurers.
  - (iv) Utilize qualified and experienced registered nurses to make initial utilization review decisions.
  - (v) Base treatment or service denials on the clinical review by a qualified physician or practitioner of the service under review.
- (b) If the CCO, rather than performing utilization review itself or by an affiliate under common ownership and control, contracts with an independent utilization review organization, the utilization review organization shall be one which has been approved by the Department of Labor and Industry and has entered into a contract with the CCO in accordance with § 122.626 (relating to contracts with independent organizations for performance of case management and communication or utilization review services).

### § 122.613. Standards for quality assurance program

A CCO shall establish, operate and maintain a quality assurance program which includes a record on file of and provides for the following:

- (1) A formal quality assurance committee consisting of participating coordinated care providers, under the direction of a medical director, which shall be responsible for approving quality assurance standards and criteria, assessing the performance of the CCO's health service delivery system, identifying quality problems and taking appropriate corrective action.
- (2) A written description of the structure and organization of its quality assurance committee and plans for documenting quality assurance activities.
- (3) Formal minutes and reports documenting the activities of the quality assurance committee, which shall be available for review by the Department and external quality review agencies.
- (4) An adequate staff of quality assurance professionals, particularly quality assurance registered nurses, to implement the quality assurance plan and objectives developed by the quality assurance committee and medical director.
- (5) The resume and job description of its medical director and other professionals responsible for conducting quality assurance activities.
- (6) A 2-year quality assurance work plan listing specific quality assurance activities the CCO will undertake in terms of focused medical care chart audits, adverse outcome reviews, credentialing activities and other activities; the estimated time frames for completion of each activity; and responsible personnel. As part of its 2-year quality assurance work plan, the CCO shall review a statistically significant sample of medical records pertaining to the treatment of injured workers. Injured workers treated by the CCO shall be selected for review and the medical records of the participating coordinated care providers that treated the injured worker shall be independently reviewed by the quality assurance system to ascertain the following:
  - (i) The quality of care provided by each provider.
  - (ii) The timeliness and appropriateness of treatment provided.
  - (iii) Verification that each physician who is a participating coordinated care provider has staff admitting privileges in at least one hospital that is a participating coordinated care provider.

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## STATEMENT OF POLICY

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- (iv) A requirement that there be disclosure to the CCO by the provider of a financial interest in another provider to which the credentialed provider may be making referrals.
  - (v) Verification of the provider's training and experience.
  - (vi) Verification of compliance with another standard the CCO adopts as part of its credentialing process, and with treatment protocols established by the CCO through its quality assurance system.
  - (vii) Establishment of standards for medical records and periodic review of medical records/charts to verify provider compliance with the standards.
  - (viii) For providers for which Health Care Cost Containment Council data is available, consideration of the data in the credentialing and recredentialing of participating coordinated care providers.
- (7) An injured worker satisfaction program which meets the requirements of § 122.614 (relating to injured worker satisfaction program).

### **§ 122.614. Injured worker satisfaction program**

- (a) A CCO shall continually conduct injured worker satisfaction surveys designed to ascertain at least the following regarding injured workers:
- (1) Satisfaction with the participating coordinated care providers, as well as nonparticipating referral providers who have treated them.
  - (2) Satisfaction with the coordination of care, case management and referrals.
  - (3) Promptness of appointments and treatment.
  - (4) Overall satisfaction with the quality of care provided.
  - (5) Satisfaction with the return to work plan and outcome.
- (b) The Department may establish a uniform injured worker satisfaction assessment survey to enhance comparative performance measurement of CCO responsiveness to injured worker needs.

### **§ 122.615. Injured worker grievance system and provision of alternatives**

- (a) The CCO shall maintain and offer the injured worker the following alternatives if the injured worker is dissatisfied with the quality of care or quality of service of a participating coordinated care provider:
- (1) The right to choose another participating coordinated care provider to provide the required medically necessary services at no cost to the injured worker.
  - (2) The opportunity to transfer to one of the other providers specified in the list provided by the employer under section 306(f.1)(1)(i) of the act (77 P. S. § 531.1(1)(i)), during the first 30 days of treatment or to transfer to an eligible provider thereafter.
  - (3) The right to file a complaint under the provisions of the CCO's injured worker grievance system.
- (b) The CCO shall offer the following alternatives to an injured worker who contests denial of medically necessary treatment or services by the CCO or a participating coordinated care provider as a result of a CCO utilization review or case management decision, or otherwise:

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## STATEMENT OF POLICY

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- (1) The right to have the CCO arrange for a second clinical opinion by a participating coordinated care provider, at no cost to the injured worker, concerning the medical necessity or appropriateness of treatment to which the injured worker alleges being denied access.
  - (2) The right to have the injured worker's claim reviewed, at the CCO's expense, by a non-CCO affiliated utilization review organization approved by the Department of Labor and Industry.
  - (3) The right to transfer to one of the other providers specified on the list provided under section 306(f.1)(1)(i) of the act, during the first 30 days of treatment or to transfer to any eligible provider thereafter.
  - (4) The right to file a complaint under the CCO's injured worker grievance system.
- (c) The CCO shall establish, operate and maintain an injured worker grievance system as one of the remedies available to the injured worker.
- (d) The injured worker grievance system shall include:
- (1) A verbal or written complaint filed by an injured worker with the CCO, as the first level of grievance. The CCO shall make a good faith attempt to address the complaint and offer an appropriate remedy or corrective action within 7 working days of its receipt of the complaint.
  - (2) A formal written grievance filed by the injured worker with the CCO if the injured worker is dissatisfied with the CCO's response to the first level grievance resolution or response, as the second level of grievance.
    - (i) The CCO shall appoint a grievance committee to conduct an informal hearing on the injured worker's grievance. The CCO may not permit a person who has had prior involvement in the review of the grievance committee. The CCO shall provide the injured worker or the injured worker's representative the opportunity to be heard. The CCO is encouraged, but not required, to include worker representation on the grievance committee.
    - (ii) The CCO shall require that the grievance committee's informal hearing be held in a timely fashion and its written decision be rendered promptly after the hearing. Generally, the conducting of the informal hearing within 20 days of the injured worker's filing of a grievance, and the rendering of the decision of the grievance committee within 10 days of the informal hearing shall be considered prompt.
    - (iii) The CCO shall ensure that the decision on the formal written grievance includes the committee's rationale for its decision and written notification to the injured worker of the right to appeal the decision to the Department.
    - (iv) The CCO shall require that a transcript be taken of the informal hearing and that the record of the informal hearing be forwarded to the Department if the injured worker appeals the decision of the grievance committee.
  - (3) The CCO shall ensure that for issues involving medically urgent treatment in which time may be of the essence, the injured worker may ask for expedited review and is aware of that option. The CCO shall provide expedited review of the grievance by its medical director. The medical director shall decide the grievance, inform the injured worker in writing of the decision and rationale for it, and inform the injured worker of the worker's right to appeal the decision to the Department. In these cases, the medical director's decision shall be rendered within 48 hours of the injured worker's request for an expedited grievance review.
- (e) The injured worker shall have the right to appeal a decision of the CCO's grievance committee or medical director to the Department. The Department will have authority to overturn the decision of the

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## STATEMENT OF POLICY

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grievance committee or medical director and order the CCO to afford the injured worker an appropriate remedy or to improve its quality of care to the injured worker.

(f) The CCO shall be responsible for paying the cost of independent clinical opinions from qualified providers or utilization review organizations approved by the Department of Labor and Industry which are requested by the Department to assist it in considering a grievance appeal.

(g) The CCO shall maintain a log of complaints and grievances filed by injured workers, in which the CCO shall record response times and dispositions, and shall make the log available for review and inspection by the Department.

(h) The CCO shall provide to an injured worker who communicates dissatisfaction with the quality of care or service received or who claims denial of medically necessary treatment or services, a written description of alternative remedies available to the injured worker and of the grievance system.

### **§ 122.616. External quality assessment of CCOs**

(a) To ensure that CCOs are providing the high-quality care required by the act and that provision of care through CCOs is not resulting in inadequate treatment, poor quality care or inappropriate release of injured workers to return to work, the Department may arrange for external quality reviews of CCOs.

(b) The Department may direct that an external quality review of a CCO be conducted at any time.

(c) The Department may arrange for external quality reviews of a sample of CCOs to independently determine the quality of care being provided by CCOs. If a sample analysis reveals significant quality of care problems or lack of CCO commitment to documented and effective oversight of quality of care being provided to injured workers, the Department may then require all CCOs to undergo an external quality assessment.

(d) An external quality assessment shall be conducted by an external quality review organization acceptable to the Department and selected by the CCO from a list of Department-approved review entities.

(e) An external quality assessment is designed to study the quality of care being provided to injured workers and the effectiveness of the CCO's formal quality assurance structure and activities. It shall include a review of randomly selected medical records of injured workers treated by the CCO to judge matters such as compliance with medical record standards, appropriateness of diagnosis and treatment, appropriateness of referrals, continuity of care and underutilization of services.

(f) The CCO shall be responsible for contracting with the external quality review organization and paying for its services.

(g) The external quality review organization and the CCO shall arrange an acceptable date, time, place and agenda for the external review with the Department and provide Department staff with full rights of participation in and observation of the external review.

(h) The CCO shall arrange for the external quality review organization to issue a formal written report of its findings to the board of directors of the CCO and to the Department. The Department will utilize this report as an independent fact finding report and consider it in the Department's decision as to whether to require a corrective action plan of the CCO, and what the components of that plan should be, or whether the Department should pursue action to suspend or revoke the CCO certification.

### **§ 122.617. Corrective action plans**

(a) If the Department determines through direct examination or through an external quality review that there are deficiencies in a CCO's operations, the Department will identify the deficiencies to the CCO in writing.

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## STATEMENT OF POLICY

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(b) The CCO shall submit a corrective action plan within 30 days of its receipt of a deficiency letter from the Department.

(c) The Department may initiate action to revoke or suspend the certification of a CCO that fails to meet the Department's requirements for an acceptable corrective action plan within 90 days of the date of the initial deficiency letter or for failure of a CCO to implement a corrective action plan which the Department has approved.

### § 122.618. Exemptions for rural CCOs

(a) An applicant for certification as a CCO seeking to operate in a county designated as rural by the Health Care Financing Administration or in a rural Health Professional Shortage area may request an exemption from compliance with one or more requirements of section 306(f.2)(2) and (3) of the act (77 P. S. § 531.1(2) and (3)). A request shall justify the exemption sought.

(b) In reviewing the request for exemption, the Department will consider whether the potential public benefit outweighs the potential public harm attributable to the requested exemption.

### § 122.619. Access to records; inspections of CCOs

(a) The CCO shall permit the Department and its employees and agents complete and free access to the books, records, papers and documents of the CCO to enable the Department to perform its responsibilities under the act to ensure that the services provided by a CCO are in accordance with the plan for providing services included in its approved application, and that the services which are provided meet accepted professional standards for high quality, cost-effective care.

(b) The Department may review the actions or operations of a CCO to ensure its continuing compliance with standards, to address quality of care complaints or grievances or to validate data submitted in CCO reports. A review may include onsite inspection of the CCO's facilities and records.

(c) The CCO shall permit the Department and its employees and agents access to the medical records of injured workers treated by or through a CCO for the purposes of assessing quality of care and for the purposes of reviewing injured worker grievances and complaints.

### § 122.620. Role of the CCO in billing

(a) A CCO, to ensure reimbursement of its participating coordinated care providers in accordance with the reimbursement arrangements it may negotiate with an employer or workers' compensation insurer, may do the following:

(1) Require the bills of participating coordinated care providers for treatment of injured workers selecting the CCO to be sent to the CCO for repricing in accordance with its contract with the employer or workers' compensation insurer.

(2) Forward repriced, accurate bills to the self-insured employer or the employer's workers' compensation insurer for direct payment to the participating coordinated care provider.

(b) The CCO may propose for Department review other methods to ensure that participating coordinated care provider bills are accurately and promptly identified as CCO related bills subject to the negotiated fee established between the CCO and the self-insured employer or workers' compensation insurer.

### § 122.621. Referrals within a CCO

(a) Neither a CCO nor any of its participating coordinated care providers is prohibited from referring an injured worker for a medical good or service specified in section 306(f.1)(3)(iii) of the act (77 P. S. § 531.1(3)(iii)) to another participating coordinated care provider within the CCO network, irrespective of

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## STATEMENT OF POLICY

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whether the CCO or the referring participating coordinated care provider has a financial interest in the participating coordinated care provider to whom the referral is made.

(b) The CCO and its participating coordinated care providers shall provide to the injured worker a written disclosure of their financial interests, if any, in a provider to which referrals may be made.

(c) The CCO shall monitor the referrals to ensure quality, guard against overutilization, ensure that no referrals prohibited under section 306(f.1)(3)(iii) of the act are made to nonparticipating coordinated care providers, and ensure that no referrals are made to persons other than the participating coordinated care providers within the network unless preapproved by the CCO.

### § 122.622. Prohibition of risk-transfer to CCOs

A CCO may not accept financial risk for the provision of services to injured workers without securing appropriate licensure under the laws of the Commonwealth as a risk-assuming insurer, establishing appropriate systems to guard against the potential for undertreatment or poor quality care arising out of the incentive to minimize financial risk, and securing specific prior review and approval by the Department to assume the financial risk for the provision of services as a CCO.

### § 122.623. Data reporting requirements

(a) A CCO shall file an annual report with the Department for each 12 months of operation. This report shall be filed with the Department within 60 days after the end of each 12-month period and shall summarize the CCO's activities during the preceding 12-month period and include the following:

- (1) The number of self-insured employers which had offered the CCO to injured workers during the reporting period as one of the specified providers under section 306(f.1)(1)(i) of the act (77 P. S. § 531.1(1)(i)).
- (2) The number of workers' compensation insurers which had offered the CCO during the reporting period as one of the specified providers under section 306(f.1)(1)(i) of the act.
- (3) The total number of workers eligible to utilize the CCO during the reporting period.
- (4) The number of workers who actually utilized the CCO during the reporting period and the length of time of the utilization.
- (5) The number of each of the following for the reporting period: complaints and grievances filed, resolved in favor of the injured worker, decided in favor of the CCO or participating coordinated care provider, pending resolution and appealed by injured workers to the Department.
- (6) The number of each of the following for the reporting period: utilization review decisions appealed by participating coordinated care providers, settled in favor of the provider, settled in favor of the CCO and pending resolution.
- (7) The number of injured workers during the reporting period who initially selected the CCO and were still under treatment 31 days after the injury and receiving care through the CCO, and who initially selected the CCO and were still under treatment 31 days after the injury and who exercised their option to seek continued treatment from non-CCO providers.
- (8) The number of injured workers during the reporting period who selected the CCO option who returned to work within: 0—7 days; 8—14 days; 15—30 days; 31—40 days; 41—50 days; 51—60 days; 61—365 days; or more than 365 days after injury.

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## STATEMENT OF POLICY

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(9) The number of workers during the reporting period who were reinjured or requiring medical services relating to the original injury within: 0—7 days; 8—30 days; 31—90 days; 91—365 days of their return to work.

(10) The record of timeliness of delivery of services during the reporting period, as required by § 122.609(d) (relating to requirements for a CCO's health service delivery system).

(11) The cost of providing services to injured workers, for the reporting period, in a form and with specificity the Department may require.

(b) The Department may require uniform collection of data as to data required by this section or to track specific diagnoses related to the treatment of injured workers, and to require the production of the data for standardized time periods to facilitate the Department's compilation of statistics to compare CCO performance.

### **§ 122.624. Requirements for service area expansion**

(a) A CCO may apply for approval of an expansion of its service area by submitting a request for the expansion to the Department. The expansion request shall include the following:

(1) The proposed new service area, by county.

(2) A list of participating coordinated care providers in the proposed new service area who are capable of providing primary medical services and other required health services in a manner that meets the standards in § 122.609 (relating to requirements for a CCO's health service delivery system).

(3) A description of how required services such as case management and communication, utilization review and quality assurance will be extended to serve injured workers in the proposed additional service area and a description of the CCO's plans for increased staffing to expand these services.

(b) The Department will treat an application to expand a CCO's service area as an application to amend the CCO's certification.

(c) The filing fee for a service area expansion will be established by regulation. The Department anticipates that this fee will be approximately \$500.

(d) A CCO may not provide coordinated care services in a new service area until the Department has specifically approved the service area expansion request.

### **§ 122.625. Injured worker literature**

As soon as practical after an injured worker's initial contact with a CCO, the CCO shall provide the injured worker with a written description of the CCO structure, operation, provider network, quality assurance system, utilization review system, grievance resolution system, alternatives to the grievance resolution system, referral requirements and methods by which the injured worker may change providers or initiate a referral within the provider network. The CCO may arrange with an employer for the employer or insurer to distribute the literature to injured workers.

### **§ 122.626. Contracts with independent organizations for performance of case management and communication or utilization review services**

(a) A CCO shall provide quality assurance and injured worker grievance system services directly.

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## STATEMENT OF POLICY

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- (b) A CCO may, with the prior approval of the Department, contract with an independent organization for the conduct of utilization review or case management and communication services for injured workers treated by the CCO.
- (c) A CCO that intends to enter into a contract subject to subsection (b), after it becomes certified, shall submit the contract for review and approval by the Department before it enters into the contract.
- (d) The CCO will be held by the Department to have ultimate responsibility and accountability for services provided by a contractor to injured workers pursuant to a contract subject to subsection (b).
- (e) A contract subject to subsection (b) shall contain provisions which provide that:
  - (1) The ultimate responsibility and accountability for services provided by the contractor to injured workers is retained by the CCO.
  - (2) The CCO has authority to establish performance standards, monitor performance of the contractor, require corrective action and terminate the contract if the contractor is found by the CCO to be ineffective or to be conducting activities detrimental to the CCO or injured workers.
  - (3) The Department has approval authority over the contract and authority to require the CCO to take corrective action.
  - (4) The CCO and the Department shall have access to records, including medical records, relating to the provision of services to injured workers electing to receive care through the CCO.

### **§ 122.627. Changes or additions to previously approved application**

- (a) Except as set forth in subsection (b), a CCO may not engage in a material departure in its operations from the manner described in the information submitted with its application for certification without filing the proposed changes with the Department 60 days prior to the intended effective date of the changes. The filings shall be subject to the following:
  - (1) A CCO may not implement changes in contracts with participating coordinated care providers, other than as to negotiated fee levels, without specific approval of the Department.
  - (2) A CCO may implement a change or addition after expiration of the 60-day filing period if this subchapter does not specifically state that that type of change or addition requires prior Departmental approval and if the Department does not notify the CCO within 60 days of its receipt of the proposed change or addition that the change or addition is significant enough to require specific prior review and approval of the Department. If so notified by the Department, the CCO may not implement the change or addition until the Department has formally approved the change or addition.
- (b) A CCO may add and delete participating coordinated care providers within its approved service area, as long as it maintains sufficient numbers and specialty distribution to provide primary care medical services. Changes in updated provider lists shall be filed with the Department semiannually on or before July 30, covering the period January to June, and with the annual report required by § 122.623 (relating to data reporting requirements).