Guide for the Treating Physician
In the Workers’ Compensation System

October 2015
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Our Mission

The mission of Harbor Health Systems (Harbor) is to maximize the impact of top doctors on workers compensation claims.

We believe the greatest potential impact on reducing the total cost of workers’ compensation comes from getting the injured workers to doctors with a track record of positive outcomes in workers compensation.

Introduction to Harbor Programs

Welcome to the Harbor Medical Provider Networks (MPN) Programs

Harbor manages multiple MPN programs that focus on outcomes-based network management strategies to assure that our client’s injured workers have the best available doctors in their networks.

As your partner, we are committed to help you have the greatest impact possible on the workers’ compensation claims that you treat in our program. We strive to not only recruit the best doctors, but to also provide resources that help all doctors succeed in our programs.

To that end, we’ve compiled multiple resources including this training guide.

The purpose of the training guide is to give all providers involved in our programs a baseline understanding of the workers’ compensation system and your obligations as the treating Physician, an understanding of MPNs, and information about Harbor and the programs we deliver to our customers. We have included resources materials, contact numbers, and key forms to help you and your office manage the care of the injured workers you treat.

Who is Harbor?

Harbor Health Systems (Harbor) was founded in 2001 with a vision of impacting the total cost of workers compensation by focusing on the doctors outcomes as a key driver for managing care direction. Prior to the introduction of the MPN, we focused on HCO programs, assisting most of the certified programs in areas like compliance and physician network selection and management.

When the MPN regulations were first introduced in 2004, we redirected our efforts toward this new model as a key component of fulfilling our mission to maximize the impact of top doctors – an approach that was very different than most of our competitors at that time who focused on PPO optimization. For the first four years of the MPN, we had helped many payer’s launch their programs using the same solutions we initially developed for the HCO market.
In 2008, we introduced the first ever outcomes-based network MPN, a program that was initially implemented by Sears but quickly grew to include many of the top self-insured companies that were seeking a better way to manage the care for their own employees. Since its introduction, this program has reduced the total cost of workers’ compensation for our clients by as much as 15% each of the years it has been in place.

One Call Care Management acquired Harbor in 2012 with a vision of combining the best doctor strategy of Harbor with the One Call strategy to integrate the top ancillary services companies. Harbor continues to run as an autonomous subsidiary within the One Call family of companies to allow it to focus on outcomes programs and the California MPN. The integration of Harbor into the One Call enterprise has allowed us to significantly improve the services we offer within the MPN, and extended or ability to streamline care delivered to injured workers. As part of the largest workers’ compensation care delivery company in the nation, we have access to resources and support that allows us to drive innovations that we feel will change workers comp over the next decade and beyond.

What is an MPN?

California law created the MPN model in 2004 as part of an effort to reign in workers’ compensation costs. The MPN is a Medical Provider Network that includes an exclusive list of physicians, facilities, and ancillary service providers authorized to treat injured workers.

MPNs are governed by the Division of Workers Compensation, under the Department of Industrial Relations. The approval process and required qualifications are detailed in the California Code of Regulations, sections 9767.1 et al.

As an MPN Applicant, Harbor is required to meet multiple accountabilities with respect to maintaining the state approvals, managing the coverage and quality of the medical network, and providing resources to assist injured workers in finding care.

How are physicians impacted by an MPN?

Under California Law, when an MPN is in place, any injured workers whose care is either started or transferred into the MPN can only be treated by doctors selected by the MPN for their physician panel unless the claims administrator authorizes out of network care. In Harbor’s MPN programs, we typically only include the number of physicians necessary to cover the employed population of our clients. As such, participating in the Harbor program can be a strategic advantage for our physician partners. It is important to note that patients may select any providers in the MPN for their care, so there is no guarantee of claims traffic to any specific participating providers.
Harbor enforces certain criteria for participation in the MPN program. Among these is the requirement that all physicians recognize they are part of a panel that reduces the number of options for injured workers, so it is critical that you make yourself available to these patients using the same criteria for scheduling as you would any other patient in your practice. Physicians who routinely refuse to take transfers of existing injured workers will be reviewed for participation and could be removed to make room for physicians who will take patients who have ongoing care needs.

The newest California law makes it clear that the MPN Applicant has the sole right to determine which doctors are included in their MPN panel of physicians. If a physician is removed from the MPN for any reason, existing claims need to be transferred to a new physician who is in the MPN. Our goal is to reduce the potential disruption in patient care, so we expect that as issues arise our participating physicians will work with us to resolve the issues quickly and efficiently to allow for continued inclusion in the MPN panel.

How do you succeed in the Harbor MPN?

Our goal is to help you succeed in our programs. We need as many great physicians as we can get, so we offer multiple opportunities for our physicians and medical groups to understand how to be successful in workers’ compensation as well as in our MPN program. In addition to outcomes, other key factors impacting your success in the Harbor MPNs are:

- Compliance with use of MPN physicians and services
- Compliance with payer’s Utilization Review policies and procedures
- Effectiveness and timing of reports delivered to claims managers
- Appropriate billing practices and compliance with network agreements
- Ability to resolve issues or concerns with respect to care, patient management, and interactions with the claims teams

Harbor’s success is measured by the overall impact our MPN has on our customer’s workers’ compensation costs, disability, and claim durations. The physician’s role impacts the patient far beyond the actual hands on care, so we want to help all participating providers understand the program, its goals, and how to be a success partner in the MPN panel.
Introduction to Harbor One MPN

Harbor Health Systems (Harbor) is a network management company that focuses on outcomes based network solutions for MPNs. We currently manage or own over 100 MPNs for customers that include many Fortune 100 companies, as well as some of the largest and most respected Third Party Administrators (TPAs), managed care companies, and carriers. Since 2008, our outcomes-based MPN programs have delivered over 15% reductions to our customer’s workers compensation costs.

The Harbor One MPN program was introduced in early 2014 to meet the changes that SB863 made to the MPN. The program includes multiple MPNs that are all based on the first MPN in this program (Harbor One MPN), which was also the first ever MPN approved and available under the newest laws allowing a network-entity to be the MPN, (approved by the DWC on May 21, 2014 – MPN Approval number 46-0588955-229). Since that program was approved, there have been several additional MPNs approved that have the same structure and policies, but have slight variations to accommodate some clients’ unique needs. The complete list of MPNs, as well as details on any variations for specific custom versions, can be found in the Harbor Physician Portal listed below.

Our program selects doctors for inclusion in these networks using a variety of data and feedback, in order to include the top doctors available to treat workers’ compensation patients. For more information on the criteria used to select and admit providers to the program, please see the section titled “Inclusion Criteria for the Harbor One MPN.”

Program Goals

The goals of the Harbor MPN program are simple:

• Provide the injured workers with a network of the best doctors available to treat the injury or illness.
• Assure network referrals go to the approved doctors, providers, and ancillary services.
• Reduce system friction for more streamlined access to care through better communication and partnership with the physician community and the injured workers.
• Positively impact the total costs of workers’ compensation claims by focusing on overall patient outcomes.

Accessing Ancillary Services in Harbor One MPN

Since Harbor is part of the One Call family of companies, we have a unique advantage in our connectivity to the largest and most respected ancillary services companies in workers’ compensation. All scheduling and customer service functions for the services included in our MPN can be arranged by the Medical Access Assistants (MAA) / Care Concierge Team.
As part of the MPN Application, Harbor selected the following ancillary service providers for inclusion in the MPN. For ancillary services, the following MPN vendors must be used unless you have obtained preauthorization to use an out of MPN vendor.

<table>
<thead>
<tr>
<th>Ancillary Service</th>
<th>MPN Vendor</th>
<th>Scheduling Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostics</td>
<td>One Call Diagnostics</td>
<td>(855) 900-6761 (Scheduled through Medical Access Assistant/Care Concierge)</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>Align Physical Therapy</td>
<td>(855) 900-6761 (Scheduled through Medical Access Assistant/Care Concierge)</td>
</tr>
<tr>
<td>Transportation</td>
<td>One Call Transport + Translate</td>
<td>(855) 900-6761 (Scheduled through Medical Access Assistant/Care Concierge)</td>
</tr>
<tr>
<td>Translation Services</td>
<td>One Call Transport + Translate</td>
<td>(855) 900-6761 (Scheduled through Medical Access Assistant/Care Concierge)</td>
</tr>
<tr>
<td>Home Health</td>
<td>One Call Home Health</td>
<td>(855) 900-6761 (Scheduled through Medical Access Assistant/Care Concierge)</td>
</tr>
<tr>
<td>DME</td>
<td>One Call Devices and Equipment</td>
<td>(855) 900-6761 (Scheduled through Medical Access Assistant/Care Concierge)</td>
</tr>
<tr>
<td>Assistance with uncommon specialties and locations</td>
<td>One Call Dental + Doctor</td>
<td>(855) 900-6761 (Scheduled through Medical Access Assistant/Care Concierge)</td>
</tr>
</tbody>
</table>
Inclusion Criteria for the Harbor One MPN

Our approach to MPNs involves strict inclusion criteria that determines who is eligible for our MPN panels of physicians. The goal of this criteria is to assure that we are (1) working with physicians that have a proven track record of successfully managing workers’ compensation patients, (2) understand how to work with our clients’ policies and procedures, (3) willing to receive and respond to feedback and issues, and (4) adopt policies and processes in their practices that we believe have a meaningful impact on the overall population of injured workers.

Physicians can access documentation on our benchmarking and inclusion policies in the provider portal listed under physician resources.

Outcomes Benchmarking

Harbor uses a proprietary outcomes benchmarking program to identify physicians with a proven track record of success in workers’ comp. We collect several years’ worth of claims data from our clients to measure claims outcomes, and use proprietary systems (MD360 and ID360) to connect physicians to their outcomes and compare them to their peer population. Peer populations are determined through a case-mix process that combines claims based on their CPT codes to assure that we measure like practices in the benchmarking process. We compare specialty to specialty and where applicable tertiary specialty.

Outcomes measured in this process include:

- Disability of claimants
- Total claims duration
- Total medical cost of claim
- Litigation and Recidivism rates

MPN Compliance

MPN compliance includes factors such as referrals to MPN approved providers, use of MPN approved vendors, and compliance with UR policies and procedures. Although no aspect of our MPNs will supersede a physician’s rights to the IMR and IBR processes, high utilization of these services without making an effort to engage our clients in resolution is factored into overall compliance.

As stated above, we are looking for doctors who demonstrate an understanding of our client’s policies and procedures. This is critical to assuring that patient care is not disrupted or delayed through miscommunication on approval requests, UR compliance, or bill review processes. Harbor in no way engages in any practice that will restrict your rights to assure you are paid within contractual agreements and state fee schedules, or your efforts to obtain the best possible care for your patient. Our goal is to assure that the providers in our program
understand the workers’ compensation well enough to manage these efforts without routinely disrupting patient care or encouraging patients to take an adversarial position to payers.

**Issues Resolution**

Harbor maintains a structured process for receiving, tracking, and managing complaints about providers in our program. We recognize that not all complaints have varying degrees of material impact, and as such have four paths for channeling issues. The first time a minor issue is entered, it will often only be tracked in our systems for the purpose of identifying trends. If a trend exists, or if an issue is more significant, an official communication will be sent to the group or provider identifying the issues. In most cases, we will reach out to your practice manager or identified contact to work through a communication and resolution process.

In more significant cases, a provider could be put on probation or removed from the program. If a physician fails to cooperate with the probation process or fails to successfully meet probation criteria they will be removed from the MPN. In all cases where the Provider is removed by Harbor for the above issues there is a structured appeals process that can be initiated if a provider wishes to make a case for return to the MPN.

**Claims and Patient Satisfaction**

In many of our programs, we solicit feedback from claims professionals and patients. As with all aspects of our criteria for participation, we seek out physicians that have a high degree of competency managing injured workers and working within the workers’ compensation system.

Claims satisfaction is mostly driven by factors such as quality of report writing, timeliness of reports, and the ability to obtain appointments and responses to questions. The goals of our patient satisfaction surveys are to identify whether the offices and staff are professional, whether the patient felt the physician understood their condition, and whether they understood the physician’s plan of care.

**Your Key Program Resources**

All doctors and medical providers can access information and support at the following three resources:

- Harbor’s online portal for physicians has materials related to the program, information on MPNs that providers are included in as well as a link to any specific requirements of the Claims Administrators for participation in their specific MPN. The website is available at:

  Harbor Provider Portal: Provider.harborsys.com

- Harbor’s Provider Relations Department can assist with contracting, credentialing, and issues related to participation in MPN programs:
Care Concierge is a service provided to our partners to assist in finding the best doctors for referrals, scheduling, and guidance for other services for patients: This is also a resource for the Physician as they will be able to tell you which Physicians and other service providers are in a specific MPN:

(Scheduled through Medical Access Assistant/Care Concierge)
Phone: (855) 900-6761
Email: mpnaa@harborsys.com

Please share these key resources and contact information with your office staff as appropriate. Again, our goal is to make the management of your workers’ compensation cases as easy as possible.

**Annual Medical Director Meeting**

To further assist you in understanding the Harbor One MPN program, we have established a Medical Director’s Meeting – with an annual meeting hosted near our headquarters in Orange County, California. You will receive invitations and “save the dates” as they are scheduled. We hope you can join us for this meeting as it is a valuable opportunity to hear from our customers, to learn more about our program, to talk to your peers, and for us to hear from you.

The next section includes an overview of the California workers’ compensation system, with a focus on the areas that are important for physicians to know about when treating injured workers, managing their care, and reporting on results. Embedded in each section are references to forms that are used in treating workers’ compensation cases.

**Overview of California Workers’ Compensation**

California Workers’ Compensation is a legislatively mandated system that requires employers to carry workers’ compensation insurance that provides an injured employee with medical treatment and compensation for occupational injuries or illnesses sustained on the job, regardless of fault of any party.

California workers’ compensation law requires claims administrators to authorize and pay for medical care that is reasonably required to cure or relieve the effects of the injury.

The Division of Workers’ Compensation (DWC) is the department under the State of California Department of Industrial Relations that monitors the administration of workers’ compensation claims, and provides
administrative and judicial services to assist in resolving disputes that arise in connection with claims for workers’ compensation benefits and may be found under: [http://www.dir.ca.gov/dwc/dwc_home_page.htm](http://www.dir.ca.gov/dwc/dwc_home_page.htm).

The injury or illness may be caused by a specific incident such as a slip and fall, or repeated exposures, such as repetitive motion over time. Everything from first-aid type injuries to serious accidents is covered, including physical and psychiatric injuries and/or injuries resulting from workplace crime.

Under laws enacted in 2003 and 2004, medical treatment must adhere to scientifically based medical treatment guidelines referred to as the Medical Treatment Utilization Schedule (MTUS). Only the treatment that meets these or other accepted evidence-based guidelines will be approved.

All employers or claims administrators handling workers’ compensation claims are required by law to have a program called Utilization Review (UR). This program is used to determine the medical appropriateness of the medical treatment plan.

It is illegal for a physician or medical facility to bill a worker if they know the injury is, or may be, work related. California workers’ compensation law is codified in the California Insurance Code, California Labor Code (LC), and Rules and Procedures of the Workers’ Compensation Appeals Board (WCAB), which appears in Title 8 of the California Code of Regulations (CCR).

The State of California has an Official Medical Fee Schedule (OMFS) which is the maximum rate at which a provider will be reimbursed. However, reimbursement is typically in accord with the PPO contract of the source network.

**Workers’ Compensation and HIPAA**

The Health and Human Services section of the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 privacy rule specifically excludes and provides an exception for workers’ compensation. The privacy rule recognizes the legitimate need of insurers and other entities involved in the workers’ compensation systems to have access to individuals’ health information as authorized by the State. Claims administrators and utilization review companies need access to the health information of individuals who are injured on the job to process or adjudicate claims, or to coordinate care under the workers’ compensation system. When an employee has submitted a claim for workers’ compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, that employee shall be deemed to have waived any privilege or confidentiality concerning any communications related to the claim or history or treatment of injury arising from the incident that the employee has had with any physicians, including, but not limited to, communications with psychiatrists or psychologists.

Therefore, HIPAA does not pertain to workers’ compensation and a medical records release form is not required.
First Aid Treatment

First aid treatment is defined by the California Labor Code as any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters or other minor injuries which do not ordinarily require medical care. This one-time treatment and follow-up visit for the purpose of observation is considered first aid even though provided by a physician or registered professional personnel. Title 8, C.C.R. section 14001(a).

If a physician treats an injured worker for a first aid injury, he/she is required to complete and submit a “Doctors First Report of Injury (DFR) or Illness (Form 5021) which is available at: www.dir.ca.gov/dwc/forms Section 6409(a). The form must be submitted to the Workers’ Compensation insurance carrier within five (5) working days of the initial examination. The carrier will then determine if the criteria of first aid is met; and, if so, will submit to the employer the related bills if the employer wishes to make direct payment for the first aid treatment. Therefore, there is no circumstance in which a physician will not complete the Doctors First Report of Injury or Illness.

Official Medical Fee Schedule (OMFS)

The Official Medical Fee Schedule (OMFS) is promulgated by the DWC Administrative Director under Labor Code section 5307.1 and can be found in sections 9789.10 et seq. of Title 8, California Code of Regulations. It is located on the DWC website at: http://www.dir.ca.gov/dwc/omfs9904.htm.

It is used for payment of medical services required to treat work related injuries and illnesses. Physician services are also addressed on this website under:

- Fact Sheet on RBRVS-based Physician and Non-Physician Practitioner Fee Schedule Effective January 1, 2014
- FAQs Physician and Non-Physician Practitioner Fee Schedule

If you have questions regarding the Official Medical Fee Schedule (OMFS) you may send an email to: DWCFeeSchedule@dir.ca.gov

Senate Bill 863 (SB863)

The Office of Administrative Law (OAL) approved the Division of Workers’ Compensation (DWC) final version of the MPN regulations August 2014, which is now in effect and posted on the DWC website at: http://www.dir.ca.gov/dwc/SB863/SB863.htm

or found in the California Code of Regulations, Title 8, Chapter 4.5. Division of Workers’ Compensation, Subchapter 1. Administrative Director-Administrative Rule.
Utilization Review

Physicians in the California workers’ compensation system are required to provide evidence-based medical treatment, scientifically proven to cure or relieve work-related injuries and illnesses in compliance with Utilization Review (UR) standards established in the California Labor Code (4610). The treatment must be preauthorized according to the Utilization review standards rulemaking, Title 8 California Code of Regulations, Sections 9792.6 et seq. Utilization review regulations may be found on the DWC website at: https://www.dir.ca.gov/dwc/dwcpropregs/UREmerRegs.htm

Medical Treatment Utilization Schedule (MTUS)

These accepted treatments are found in the Medical Treatment Utilization Schedule (MTUS), which contains a set of guidelines that provide details on which treatments are effective for certain injuries, as well as the extent, frequency, and duration of the treatment. The legislation responsible for the workers’ compensation reform required the DWC to compile evidence based guidelines which is called the Medical Treatment Utilization Schedule (MTUS). Title 8, California Code of Regulations, Sections 9792.20 – 9792.26. MTUS regulations may be found on the DWC website:

https://www.dir.ca.gov/dwc/DWCPPropRegs/MTUS_Regulations/MTUS_Regulations.htm

Treatment requests which are not addressed in the MTUS must, again, be consistent with other evidence-based scientifically accepted guidelines, with source cited.

Should the physician’s request not be consistent with the evidence-based guidelines, only a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist or chiropractic practitioner licensed by any state, competent to evaluate the specific clinical issues involved in the medical treatment services, where these services are within the scope of the reviewer’s practice may modify, delay or deny the treatment request.

Your office will be contacted by the utilization review personnel should there be any specific additional information needed to make the medical necessity decision. A peer-to-peer review may be requested by the reviewer or by the treating physician, to communicate directly to discuss specific issues of the case that justify the treatment recommendation. Office hours/availability of the physician should be provided. Although there is the possibility that perhaps the information has already been sent to the claims examiner, if it has not been received as yet by the utilization review staff, it is recommended that an additional copy of the information be provided directly to the utilization review staff, if requested. Additionally, you may receive a document in writing requesting what specific information is needed and by what date it is to be received in order to make the appropriate determination. It is recommended that your office expediently comply with sending the requested information so that a timely, appropriate decision can be rendered.
The requesting physician will receive a verbal decision, followed by a written determination in accordance with the type of review, documenting the date the decision was made, a description of the specific treatment requested and authorized, delayed, modified or denied. A utilization review decision to modify, delay, or deny a request for authorization of medical treatment remains effective for 12 months from the date of the decision without further action by the Claims Administrator with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

The medical rationale documenting the reason/s of the decision, with a description of the medical criteria or guidelines used to make the decision, as well as the name and telephone number of the physician reviewer and the hours of availability of the reviewer to discuss the determination. Utilization review organizations offer an internal appeals process to the requesting physician, which is outlined in the “Letter of Non-Certification or Modification.”

**Chiropractic, PT and OT Treating Guidelines**

For dates of injury from 1/1/04 and after, the injured worker is limited to a total of 24 chiropractic visits, 24 physical therapy visits, and 24 occupational therapy visits, unless the Claims Examiner authorizes additional visits and/or there has been a recent surgery, with the need for post-operative physical medicine. If the PTP is a chiropractor, and the injury occurs on or after 1/1/04, the chiropractor can no longer function as the PTP and must relinquish this role, once the 24-visit cap has been reached. The injured worker or their representative will need to designate a new, non-chiropractic PTP, such as a M.D. or D.O.

**Acupuncture Treating Guidelines**

Acupuncturists may function as a “physician,” per section 3209.3 of the California Labor Code, providing they hold an acupuncturist certification in California and function within their scope of practice, however are unauthorized to determine disability. Acupuncture medical treatment guidelines are found under section 9792.24.1.

**Home Health Care Guidelines**

Home health care services shall be provided as medical treatment only if reasonably required to cure or relieve the injured employee from the effects of his or her injury and prescribed by a licensed physician and surgeon. An employer or their insurer shall not be liable for household tasks the injured worker’s spouse or other member of the injured worker’s household performed prior to the industrial injury free of charge. In addition, an employer shall not be liable for home health care services that are provided more than 14 days prior to the date of the employer’s receipt of the physician’s prescription for home health care services, in accordance with Labor Code section 4600, subdivision (h). Home health care services are subject to the
utilization review and independent medical review processes set forth in Labor Code sections 4610 and 4610.5, et seq.

Home health care services include the provision of medical and other health care services to the injured or ill person in their place of residence deemed to be medically necessary for patients who are confined to the home (homebound) and require one of both of all of the following: 1) Skilled care by a licensed medical professional, an RN, PT, OT and/or speech pathologist and/or 2) Personal care services for tasks and assistance with ADLs that do not require a skill of a medical professional and/or 3) Domestic care services, such as shopping, cleaning, and laundry that the individual can no longer perform due to illness or injury.

Request for Authorization (RFA)

Medical treatment recommendations by the physician require preauthorization and must be consistent with evidence based guidelines (EBGs). A specific “Request for Authorization” form (RFA) must be used, per regulations, Chapter 4.5. Division of Workers’ Compensation, Subchapter 1. Administrative Director-Administrative Rules, Article 5.5.1. Utilization Review Standards which can be found at the DWC website at: https://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFA.pdf.

Clinical information, with medical rationale and objective testing to support the requested medical treatment request, must accompany the RFA form.

Independent Medical Review (IMR)

Should utilization review deny, delay or modify a treating physician’s request for medical treatment because the treatment is not determined to meet medical necessity, the physician, injured employee or their attorney can ask for a review of that decision through an Independent Medical Review process, known as IMR (Title 8, California Code of Regulations, Sections 9785, 9785.5, 9792.6, 9792.6.1, 9792.9, 9792.9.1, 9792.10, 9792.10.1, 9792.10.2, 9792.10.3, 9792.10.4, 9792.10.5, 9792.10.6, 9792.10.7, 9792.10.8, 9792.10.9, 9792.12). IMR regulations may be found on the DWC website at: https://www.dir.ca.gov/dwc/DWCPreprgs/IMR/IMR_Regs.htm.

The California Workers’ Compensation system uses this process, called IMR, to resolve disputes about the medical treatment of injured employees, with the intent of avoiding costly court time and litigation.

The costs of IMR are paid by claims administrators who are required by law to provide injured employees with all medical treatment that is reasonable and necessary to cure or relieve the effects of a work-related injury. The DWC is required to contract with one or more independent medical review organizations (IMROs) to conduct IMR on its behalf. The final determination issued by the independent review organization shall be deemed to be the determination of the Administrative Director and shall be binding on all parties.
Medication Management

According to the California Labor Code, the physician is to prescribe generic drugs unless clearly documenting the medical/clinical rationale that brand drugs are required. The physician must comply with the drug formulary authorized by State governing bodies, and/or the client’s Pharmacy Benefit Management (PBM) or Utilization Management program, as indicated.

The physician is to prescribe medication in accordance with the MTUS Chronic Pain Treatment Guidelines, which are available at: www.dir.ca.gov/dwc/MTUS/MTUS_RegulationsGuidelines.

The physician should be familiar with the State Prescription Drug Monitoring Program (PDMP) system which is mandatory as of January 1, 2016 Additional information for the California PDMP can be found at: http://oag.ca.gov/cures-pdmp.

For questions, please contact: cures@doj.ca.gov.

Physician Reporting

Physician reporting requirements are addressed under Title 8. Industrial Relations, Division 1. Department of Industrial Relations, Chapter 4.5. Division of Workers’ Compensation, Subchapter 1. Administrative Director-Administrative Rules, section 9785, entitled Reporting Duties of the Primary Treating Physician.

Causation should be addressed as appropriate, indicating the medical likelihood that the diagnosis is causally related to the mechanism of injury alleged. In order for the injury to be compensable, California statutory requirement is that the injury/illness must arise out of and in the course of the employment. Arising out of conveys the idea of a causal relationship between the incident and the injured workers’ diagnosis. The injury may be as a result of a single incident, a disease or emotional disorder, or a series of minor traumatic insults, referred to as cumulative trauma.

Within five (5) working days of the initial visit, a “Doctor’s First Report of Injury or Illness (DFR Form 5021)” must be completed and sent to the Claims Administrator. This must be submitted by each new Primary Treating Physician (PTP). The form must be completed including the information regarding frequency and duration of planned treatments, consultations, referrals, surgery or hospitalization and the type, frequency and duration of planned physical medicine treatment on the reverse side of the form. These forms are available at: http://www.dir.ca.gov/dwc/forms.

When continuing medical treatment is provided, the PR2 shall be submitted no later than forty-five (45) days from the previous report but no later than twenty (20) days of the examination. These forms are available at: http://www.dir.ca.gov/dwc/forms.
Additional PR2 reports shall be submitted within twenty (20) days if the injured workers’ condition undergoes a previously unexpected significant change, or there is any significant change to the treatment plan reported previously, or the injured worker is felt to be capable of returning to modified or regular work, or the injured worker’s condition requires him/her to leave work or requires changes in the work restrictions, the injured worker is released from medical care, or the injured worker is felt to be unable eventually to return to his/her usual occupation or the occupation in which the injured worker was engaged in at the time of the injury.

If a narrative report is submitted, it should be clearly titled “Primary Treating Physician’s Progress Report” and should contain the same information as the PR2. A narrative report must have the mandated declaration below the signature of: “I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code 139.3.”

When the physician determines that the injured worker’s condition is permanent and stationary (P&S) and has reached maximal medical improvement (MMI), the physician shall report this within twenty (20) days from the date of examination any findings concerning the extent of permanent impairment and limitations and any need for continuing and/or future care on the “Primacy Treating Physician’s Permanent and Stationary Report,” which is Form PR3 or PR4. These are available at: [http://www.dir.ca.gov/dwc/forms](http://www.dir.ca.gov/dwc/forms).

For permanent disability evaluation performed pursuant to the permanent disability evaluation schedule adopted on or after January 1, 2005, the primary treating physician’s reports concerning the existence and extent of permanent impairment shall describe the impairment in accordance with the AMA Guides to the Evaluation on Permanent Impairment, 5th Edition (DWC Form PR-4). Qualified Medical Evaluators and Agreed Medical Evaluators may not use DWC Form PR-3 or DWC Form PR-4 to report. Permanent disability evaluation should be performed in accordance with the AMA Guides to the Evaluation on Permanent Impairment, 5th edition. The physician is also able to refer the injured worker to another MPN physician for this report and likely should discuss this process with the claims examiner.

**Disability Management**

A critical role of the treating physician is disability management. Ongoing physician communication with the claims adjuster, nurse case manager, and employer, as indicated, is encouraged. Prompt return to work (RTW) in a capacity suitable for the injured worker’s abilities and need for restrictions reinforces self-esteem and improves therapeutic outcome. Injured workers, if necessary, can be placed in different jobs from their usual duty or their usual job can be temporarily modified to accommodate their limitations (“modified duty” or “light duty”). In time, with progressive clinical improvement, these restrictions should be modified to accommodate a greater work capacity. Ultimately, this results in a greater chance of the injured worker achieving total recovery.

The physician-patient relationship is critical to a return to work effort. The patients frequently require reassurance that they will not further injure themselves, they require assurance that they are not relinquishing their rights or benefits. They must be reassured that you, as their treating physician, are a partner in this process and you must continue to “represent” yourself as their advocate. This is most effectively accomplished
by the physician with direct dialogue for reassurance and sufficient explanation of the return to work process to the injured worker. It is critical that the treating physician conveys to the injured worker that participation in return to some type of work is in the patient’s best interest; indeed it is felt to be “therapeutic” and an integral part of the recovery process. The injured worker should be assured by the physician that return to some type of work does not imply closure of the claim or completion of medical care; the injured worker must be assured that he/she is not altering the status of the claim by returning to some type of work. This is a frequent misconception of the injured worker and should be proactively addressed by the treating physician.

Injured workers may doubt that any modification of their job duties is available to them. The treating physician must assure the injured worker that limitations set forth will be in writing, and should the injured worker feel that the actual work required once he/she has returned to work exceed what the restrictions are, the injured worker should contact the claims examiner. Best practice to assure the injured worker of this process is to be certain that the injured worker has the name and telephone number of the claims examiner if indeed contact needs to be made. It is incumbent on the employer to make these accommodations and if the employer is unable to accommodate the written restrictions, this will be communicated by the employer to the claims examiner. The claims examiner will then initiate temporary disability payments. This is additional assurance to the injured worker that their income will remain intact and will help to alleviate substantial anxiety following an injury.

The written form should contain the injured workers’ name, date of injury, and claim number. Additionally, the specific restrictions should be clearly stated. For example, the limitation on lifting should specify the number of pounds that can be lifted and the frequency of lifting. If the injury involves a lower extremity, the restriction may be the limitation to time and distance walked or standing, climbing and kneeling. The return to work form should also list the specific date the injured worker is to return to the office. In addition, any other appropriate comments should be included on the form such as the frequency of physical medicine treatments the patient must attend. This again reassures the injured worker that medical treatment will continue as deemed necessary by you as the treating physician.

As the injured workers’ condition improves, the degree of restriction should decrease. This is termed “functional restoration”: the need for treatment decreases as the physical ability of the patient increases. Ultimately this will allow the injured worker to return to his/her normal occupation and duties.

## Conclusion

We hope you have found this training manual a valuable resource. If you have any questions, you can contact these resources created for our Harbor One MPN physicians and their office staff, including contacting us directly.

Harbor Provider Relations Department at: networks@harborsys.com or Phone: 888-626-1737