STATE OF CONNECTICUT
WORKERS' COMPENSATION COMMISSION

EMPLOYER MEDICAL CARE PLANS
INFORMATION PACKET

Enclosed are informational materials on workers' compensation employer medical care plans in the State of Connecticut. Please reference Connecticut General Statute § 31-279 and Administrative Regulation § 31-279-10, for a listing of the information required in a medical care plan application.
A checklist has been provided to assist you.

Should you have any questions, please contact Terri Miro at (860) 493-1500.

Please be advised that the statute which grants authority for workers' compensation medical care plans is Connecticut General Statute § 31-279, subsections (c) and (d).

Sec. 31-279. Notice of availability of compensation. Uniform system for determination of degree of physical impairment. Employer-sponsored plan for medical care and treatment. Indemnification of medical advisory panel members.

(c) (1) Any employer or any insurer acting on behalf of an employer, may establish a plan, subject to the approval of the chairman of the Workers' Compensation Commission under subsection (d) of this section, for the provision of medical care that the employer provides for treatment of any injury or illness under this chapter. Each plan shall contain such information as the chairman shall require, including, but not limited to:

(A) A listing of all persons who will provide services under the plan, along with appropriate evidence that each person listed has met any licensing, certification or registration requirement necessary for the person to legally provide the service in this state;

(B) A listing of all pharmacies that will provide services under the plan, to which the employer, any insurer acting on behalf of the employer, or any other entity acting on behalf of the employer or insurer shall make direct payments for any prescription drug prescribed by a physician participating in the plan;

(C) A designation of the times, places and manners in which the services will be provided;

(D) A description of how the quality and quantity of medical care will be managed; and

(E) Such other provisions as the employer and the employees may agree to, subject to the approval of the chairman.

(2) The election by an employee covered by a plan established under this subsection to obtain medical care and treatment from a provider of medical services who is not listed in the plan shall suspend the employee's right to compensation, subject to the order of the administrative law judge.

(d) Each plan established under subsection (c) of this section shall be submitted to the chairman for his approval at least one hundred twenty days before the proposed effective date of the plan and each approved plan, along with any proposed changes therein, shall be resubmitted to the chairman every two years thereafter for reapproval. The chairman shall approve or disapprove such plans on the basis of standards established by the chairman in consultation with a medical advisory panel appointed by the chairman. Such standards shall include, but not be limited to: (1) The ability of the plan to provide all medical and health care services that may be required under this chapter in a manner that is timely, effective and convenient for the employees; (2) the inclusion in the plan of all categories of medical service and of an adequate number of providers of each type of medical service in accessible locations to ensure that employees are given an adequate choice of providers; (3) the provision in the plan for appropriate financial incentives to reduce service costs and utilization without a reduction in the quality of service; (4) the inclusion in the plan of fee screening, peer review, service utilization review and dispute resolution procedures designed to prevent inappropriate or excessive treatment; and (5) the inclusion in the plan of a procedure by which information on medical and health care service costs and utilization will be reported to the chairman in order for him to determine the effectiveness of the plan.

STATE OF CONNECTICUT

REGULATION

OF

WORKERS' COMPENSATION COMMISSION

Concerning

Medical Care Plans

(a) All medical care plans submitted pursuant to Section 31-279 of the Connecticut General Statutes by any employer or, on behalf of one or more employers, by any insurer, mutual employer association, self-insurance service organization or other sponsoring organization to arrange for the provision of medical and health care services, including medical and surgical aid or hospital and nursing service and medical rehabilitation services, shall include the following in addition to the information required by said section:

(1) The identity of any company or organization which will participate in the operation of the medical care plan, a description of such participation and, where applicable, the following:

(A) a certificate from the Secretary of the State and/or the Insurance Commissioner regarding the company or organization's good standing to do business in the State of Connecticut;

(B) a copy of the company or organization's balance sheet at the end of its most recently concluded fiscal year, along with the name and address of any public accounting firm or internal accountant which prepared or assisted in the preparation of such balance sheet;

(C) a list of the names, business addresses and official positions of members of the company or organization's board of directors or other policymaking body and of those executive officers who are responsible for the company or organization's activities with respect to the medical care plan;

(D) a list of the company or organization's principal owners;

(E) in the case of an out-of-state company or organization, a certificate that such company or organization is in good standing in its state of organization;

(F) the identity, address and current relationship of any related or predecessor company or organization; "related" for this purpose means that a substantial number of the board or policymaking body members, executive officers or principal owners of both companies are the same; and

(G) in the case of a Connecticut or out-of-state company or organization, a report of the details of any suspension, sanction or other disciplinary action relating to such company or organization in this state or in any other state.

(2) A description of the general financial arrangements between the employer, insurer, mutual employer association, self-insurance service organization or other sponsoring organization and any company or organization participating in the operation of the medical care plan, and a description of the financial arrangements with the providers of health care and medical services, including any fee schedule(s) or formula(s) used to determine the fees of such providers. To the extent permitted by law, the information required in this subdivision shall be confidential and may be reviewed only by the Chairman of the Workers' Compensation Commission or his designee.

(3) A general description of the medical care plan, including the responsibilities of the following:

(A) the employer, insurer, mutual employer association, self-insurance service organization or other sponsoring organization;

(B) any company or organization identified in subdivision (1) of subsection (a);

(C) providers of health care and medical services; and

(D) employees covered under the plan.

(4) Provision that such plan applies only to illnesses or injuries incurred by employees covered under the plan subsequent to the effective date of the medical care plan.

(5) Provision that all medical and health care services that may be required within the service area identified by the plan shall be available at the offices of participating providers during regular or extended office hours, and through participating hospital emergency rooms for emergency cases which cannot be treated at the offices of participating providers during such regular or extended office hours. The numbers and locations of such participating providers, including hospital emergency rooms, shall be such that care may be provided immediately for emergency cases, that an initial evaluation and either appropriate care or referral to other plan providers may take place within twenty-four (24) hours for an injury or disease not previously treated which is not an emergency case, and that other necessary care will be provided as appropriate. With respect to hospital emergency rooms and other providers of emergency care, the plan shall indicate its minimum criteria for distance and/or travel time to such emergency care facilities from the employer's principal employment locations.

(6) A list of all employee and contract providers included within the plan; in the case of contract providers, their relationships with the plan shall be described in a written agreement, a copy of which shall be made available to the Chairman of the Workers' Compensation Commission at his request. Said list of providers shall be filed with the plan's application for approval, updated for changes at least quarterly and shall include:

(A) at least one occupational health clinic, auxiliary occupational health clinic or hospital that has a Board Eligible or Board Certified Occupational Health Physician.

(B) at least three providers (not in the same group or practice) or two providers (not in the same group or practice) with a minimum choice in total of five individual providers of each of the following types of medical and health care service:

(i) Cardiology;
(ii) Chiropractic Medicine,
(iii) Dentistry;
(iv) Dermatology;
(v) Family Practice;
(vi) Gastroenterology;
(vii) General Hospital Service;
(viii) General Surgery;
(ix) Internal Medicine;
(x) Neurology;
(xi) Neurological Surgery;
(xii) Obstetrics and Gynecology;
(xiii) Ophthalmology;
(xiv) Optometry;
(xv) Orthopedic Surgery;
(xvi) Otolaryngology;
(xvii) Physical Medicine and Rehabilitation;
(xviii) Physical Therapy;
(xvix) Plastic Surgery;
(xx) Podiatry;
(xxi) Psychiatry;
(xxii) Psychology;
(xxiii) Pulmonary Medicine;
(xxiv) Radiology;
(xxv) Thoracic Surgery;
(xxvi) Urology; and
(xxvii) Service from such other providers of medical and health care service as determined by the plan to be necessary.

(7) A description of the selection criteria and removal procedures for providers of medical and health care services under the medical care plan. This provision shall not be construed to require a medical care plan to accept all providers who apply for participation and meet the selection criteria. To the extent permitted by law, the information required in this subdivision shall be confidential and may be reviewed only by the Chairman of the Workers' Compensation Commission or his designee.

(8) A written description of the plan's review and appeal procedures and standards for service utilization review and dispute resolution adopted pursuant to subsections (e) and (h) of this regulation.

(9) A copy of the information to be distributed to employees covered by the medical care plan. This information shall be written in plain language and include the following:

(A) a description of the medical care and treatment services available from providers of medical and health care services listed in the plan;

(B) the manner in which the employee or his representatives may obtain medical and health care services, whether from plan providers or other providers;

(C) a description of the procedures by which an employee may question or dispute the level of benefits paid under the plan; and

(D) a detailed description of an employee's right to obtain medical care and treatment services from a provider of medical services who is not listed in the plan and the employee's financial and other obligations in the event the employee exercises this right.

(10) A statement by the employer that an eligible employee's participation in the medical care plan is not inconsistent with any collective bargaining agreement affecting such employee and that a copy of the applicable collective bargaining agreement will be made available to the Chairman on request.

(11) In the case of an insurer, mutual employer association, self-insurance service organization or other sponsoring organization, a statement that each employer whose employees are eligible to participate in the medical care plan has given written consent to such participation and such written consent is in the insurer's, association's or organization's possession and will be made available to the Chairman on request.

(12) Provision that a request made by an employee to be examined for a second opinion by a reputable practicing physician or surgeon not listed in the plan shall be considered reasonable and shall be paid for by the employer if such request is submitted to and approved by an Administrative Law Judge. For these purposes, a reputable practicing physician or surgeon shall be a physician or surgeon on the approved list of practicing physicians, surgeons, podiatrists and dentists established by regulation.

(b) The Chairman may approve plans which include employee or contract providers for some but not all of the types of medical and health care service required by subparagraph (B) of subdivision (6) of subsection (a) of this section so long as the following requirements are satisfied:

(1) the plan provides to the employees the name, address and telephone number of each contract and employee provider of the plan;

(2) for each type of medical and health care service not provided by employee or contract providers, the plan shall clearly indicate that such service is available from practitioners on the approved list of practicing physicians, surgeons, podiatrists and dentists established by regulation;

(3) the plan complies with all other requirements of this regulation except, in the case of practitioners on the approved list who are not employee or contract providers and who are not providing medical and health care services pursuant

to an employee's election to obtain their services rather than the services of a plan provider, the service utilization review and dispute resolution provisions of subsection (e) shall not apply.

(c) Medical care plans submitted on behalf of employers having twenty-five (25) or more employees shall include a labor-management safety committee for each such employer with representatives of labor at least equal in number to representatives of management, in compliance with regulations established by the Workers' Compensation Commission in Sections 31-40v-1 through 31-40v-11**,** unless such committee representation is inconsistent with a collective bargaining agreement.

(d) Medical care plans submitted on behalf of employers having fifty (50) or more employees shall include provision for plan providers to evaluate the capacity of injured employees of such employers to return to their most recent employment, with or without modification, or to another position with their employer. Such providers shall indicate any limitations on the ability of such employees to perform work related tasks.

(e) Each medical care plan shall include provision for both a service utilization review providing a method to evaluate the necessity and appropriateness of medical and health care services recommended by a provider, and a means of dispute resolution if payment for such medical and health care services is denied. Such service utilization review and dispute resolution shall include, at a minimum, the following review and appeal procedures:

(1) Initiation of a review by any one or more of the following parties: the employee, the provider, the employer, or the medical care plan itself, either directly or through a utilization review contractor. If a party other than the plan initiates the review, such party shall supply to the plan all information in its possession which is relevant to the review. The plan may also request such information as it deems necessary to conduct the review.

(2) Upon receipt of all proffered and requested information, the plan shall review such recommended treatment, utilizing written clinical criteria which have been established by the plan and periodically evaluated by appropriate providers of medical and health care services required under Chapter 568 of the Connecticut General Statutes.

(3) Not more than two (2) business days after receipt of all such information, the plan shall provide written notice to the provider and employee of its determination regarding the recommended treatment. Any written notice of a determination not to certify an admission, service, procedure or extension of stay shall include the reasons therefor and the name and telephone number of the person to contact with regard to an appeal. The provider and the employee shall also be provided with a copy of the written review and appeal procedures.

(4) The provider or the employee may, within fifteen (15) days of the written notice of determination, notify the plan of his or her intent to appeal a determination to deny payment for the recommended treatment.

(5) Upon such appeal, the plan shall provide, at the request of the employee or provider, a practitioner in a specialty relating to the employee's condition for the purpose of reviewing the plan's initial decision.

(6) Within fifteen (15) days of the request for such review and submission of any further documentation regarding the review, the reviewing practitioner shall submit his opinion regarding such recommended treatment to the medical director of the medical care plan who shall, within fifteen (15) days thereafter, render a written decision regarding such treatment.

(7) The employee, the provider or the employer may request a further review of the medical director's written decision; such request for further review shall be in writing and shall be submitted to the chief executive officer of the medical care plan within fifteen (15) days of the medical director's written decision. The party requesting further review shall have an opportunity for a hearing if such party requests it in writing and may, at such party's expense, produce whatever written support or oral testimony it wishes at any such hearing. Such hearing shall be conducted within fifteen (15) days of the written request therefor. The chief executive officer of the medical care plan shall make any

final determination of such request for further review and may utilize an advisory committee to assist him in his determination. The chief executive officer shall issue a final written decision on the request for further review as soon as practical but, in any event, within thirty (30) days of the later of the date of submission of the written request for such review or the date of conclusion of the hearing requested as part of such review.

(8) In the case of an emergency condition, an employee or his representative shall be provided a minimum of twenty-four (24) hours following an admission, service or procedure to request certification and continuing treatment for that emergency condition before a utilization determination is made. If a determination is made not to provide such continuing treatment and the employee or his representative, the provider, or the employer requests a review of such determination, an expedited review shall be conducted by the medical director and a final decision rendered within two (2) days of the request for review.

(f) The necessity and appropriateness of medical and health care services recommended by providers of a medical care plan shall not be subject to review by an Administrative Law Judge until the plan's utilization review and dispute resolution review and appeal procedures, as described in subsection (e) have been exhausted. The decision of the chief executive officer of the plan relating to payment for such medical and health care services shall be subject to modification only upon showing that it was unreasonable, arbitrary or capricious.

(g) Each medical care plan shall include a quarterly report to the Chairman describing the result and number of appeals processed pursuant to the utilization review and dispute resolution review and appeal procedure set forth in subsection (e).

(h) The service utilization review and dispute resolution review and appeal procedures of subsection (e) shall, at a minimum, satisfy the following standards:

(1) Nurses and other health professionals other than physicians making utilization review recommendations and decisions shall hold current and valid licenses from a state licensing agency in the United States. Physicians making utilization review recommendations and decisions shall hold current and valid licenses in the State of Connecticut.

(2) Utilization review staff shall be generally available by toll-free telephone, at least forty hours per week during regular business hours.

(3) Each utilization review professional shall comply with all applicable state and federal laws to protect the confidentiality of individual medical records; summary and aggregate data shall not be considered confidential if it does not provide sufficient information to allow identification of individual patients.

(4) All hospitals which are plan providers shall permit licensed utilization review professionals to conduct reviews on the premises. Each utilization review professional shall conduct its telephone and on-site information gathering reviews and hospital communications during the hospitals' reasonable and normal business hours, unless otherwise mutually agreed. Utilization review professionals shall identify themselves by name and by the name of their organization, if any, and, for on-site reviews, shall carry picture identification.

(5) The provider being reviewed shall provide to each utilization review professional, within a reasonable period of time, all relevant information necessary for the utilization review professional to certify the admission, procedure, treatment or length of stay. Failure of the provider to provide such documentation for review shall be grounds for a denial of certification in accordance with the policy of the utilization review organization or medical care plan.

(6) No utilization review professional may receive any financial incentive based on the number of denials of certification made by such professional.

(7) Any medical care plan which engages directly in utilization review and any utilization review contractor which performs utilization review on behalf of a medical care plan shall, according to law, be licensed by the Commissioner of Insurance as a utilization review company.

(i) Each medical care plan shall include a procedure for reporting information annually which provides, at a minimum, the following:

(1) data comparing employees treated under the medical care plan with employees treated outside the medical care plan, either because their illnesses or injuries were incurred before the effective date of such plan or because they exercised their right to select their own providers outside the plan, and such comparisons shall be made in terms of:

(A) type of care; (B) volume of care; (C) cost of care; and (D) lost time days per employee.

(2) the number of employees who began their treatment under the plan but subsequently sought treatment outside the plan, such data to be expressed both in absolute numbers and as a percentage of the average employee plan population.

(j) Medical care plans may include, as a means of reducing service costs and utilization, the use of appropriate employees or designated contract providers as care managers or coordinators; such care managers or coordinators shall be licensed, as required by law and as provided in subsection (h) of this regulation and may have the following duties:

(1) To assist employees in obtaining initial treatment and subsequent referrals to providers of medical and health care services within the plan.

(2) To monitor the employee's progress under the treatment plan designed for that employee and make suggested changes or modifications in such treatment plan in the interests of quality care and cost-effective delivery of such quality care.

(3) To communicate appropriately with the employer, insurer, self-insurance service organization or other claim administrator with respect to the employee's medical and health care treatment and recommended payment therefor.

(k) Nothing in this section is intended to prohibit an employer from providing more than one medical care plan for its employees, either directly or through an insurer, mutual employer association, self-insurance service organization or other sponsoring organization.

Administrative Regulation § 31-279-10 Checklist

Proposed Effective Date:

- At least 120 days from application submission
- Medical Care Plan Certification must be renewed every 2 years
- Medical Care Plan covers only those injuries/illnesses incurred after effective date.

Plan Organization:

- Plan Name
- Sponsor Name
- Type of business (insurer, TPA, mutual, employer, other)
- State of incorporation (attach Certificate of Good Standing)
- Sponsor's balance sheet and accounting firm
- Board of Directors (names, positions & responsibilities)
- Principal owners and any predecessor or related companies
- Any disciplinary actions? (attach report)
- Subcontractors providing plan operation services:

    1. Name & address of subcontractor
    2. Certificate of Good Standing
    3. Description of contracted services

Fee Arrangements *(Confidential)*

- Describe the plan's fee arrangements with employers, providers & subcontractors
- Attach fee schedule and formulas used

Plan Responsibilities

- Provide a description of the responsibilities of each as relates to the operation and participation in the plan:

Sponsor:

- Insurance Claims Personnel
- Subcontractor(s)
- Licensed Case Managers
- Medical Director, Chief Executive Officer

Employer:

- Statement that plan participation is not in conflict with any collective bargaining agreement. Copy of agreement to be available to Chairman on request.

- Description of Modified/Light Duty Work Program.

- Copy of plain language explanation to be distributed to employees. How and where services are available, penalty for outside network treatment.

- Safety Committees in accordance with CGS § 31-40v.

  Attach names, titles, and addresses of committee members.

  NOTE: More than one plan per employer allowed.

Medical Providers:

- Agreement to follow plan procedures

- Provision for Return to Work Evaluation

Employees:

- Methods for reporting injury
- Mandatory treatment within the plan for those services covered under an approved plan

Medical Provider Information to include the following:

- Identify service area
- Emergency care to be available at participating hospitals.
- 24 hour initial or referral of non-emergency care.
- List all providers alphabetically by specialty and location, to be updated at least quarterly. Include phone numbers.
- Provide copy of written provider agreement describing the relationship with the plan. Copies of all executed contracts to be made available to the Chairman on request.
- Provide a description of the selection and removal criteria for plan providers. *(Confidential)*
- Network shall include at least one occupational health clinic, auxiliary, occupational health clinic or hospital with a board eligible/certified occupational health physician.
- Specialties: Minimum of three providers in three unrelated groups, or five providers in two unrelated groups.

Cardiology
Chiropractic Medicine
Dentistry
Dermatology
Family Practice
Gastroenterology
General Hospital
General Surgery
Internal Medicine
Neurology
Neurosurgery
Ob-Gyn
Ophthalmology
Optometry
Orthopedic Surgery
Otolaryngology
Physical Medicine & Rehabilitation
Physical Therapy
Plastic Surgery
Podiatry
Psychiatry
Psychology
Pulmonary Medicine
Radiology
Thoracic Surgery
Urology
Other

- Plans may choose not to cover all specialties. However, the plan must indicate that non-covered services are available without penalty from any provider on the Workers' Compensation List of Approved Providers and services are not subject to the plan's fees, review or appeal procedures.

Utilization Review & Appeal Procedures & Standards:

- Provide a description of the plan's established written clinical criteria for Utilization Review.

- Provide a description of Utilization Review procedures.

- Utilization Review is to be conducted by licensed review professionals. Physicians must be licensed in the State of Connecticut. Nurses and others must hold current and valid licenses from any state. Attach names, positions, and states of licensure of all individuals conducting Utilization Review.

- In order to assure that the company which conducts utilization review within your workers' compensation medical care plan meets the requirements set forth by administrative regulation §31-279-10, complete the attached *standards for compliance* document [see following pages]. Please note that the certification must be executed by someone in authority at the entity which is applying for the certificate to conduct the medical care plan.

- Toll-free access minimum 40 hours per week during regular business hours.

- Provision for protecting the confidentiality of individual's medical records.

- Plan hospitals to allow on-site review.

- Providers to give all relevant information for review. Failure is grounds for denial.

- Financial incentives for denials prohibited.

Initial Review:

- May be requested by an employee, employer, provider, the plan or its UR contractor. The plan must respond to a review request within two business days of the request.

Appeal:

- The plan must allow a minimum of 15 days to appeal the initial non-certification to the plan's Medical director.

Medical Director:

- Shall assign the case to a Physician Reviewer in the same or similar specialty as the condition. The Physician Reviewer shall report back to the Medical Director within 15 days of the request or receipt of additional information. The Medical Director shall then issue his/her decision within 15 days.

- The plan shall allow a minimum of 15 days to appeal the decision of the Medical Director to the plan's Chief Executive Officer. A hearing before the CEO may be requested in writing. Written and oral evidence may be presented. The hearing shall be held within 15 days of the request.

Chief Executive Officer:

- May use the assistance of an advisory committee. The CEO shall issue his/her decision within 30 days of the hearing conclusion or appeal request. The decision of the CEO shall be final, and appealable to an Administrative Law Judge only on grounds of unreasonable, arbitrary or capricious.

Expedited Appeals:

- 24 hours shall be allowed following an emergency admission, service, procedure to request certification and continuation of treatment. A denial may be appealed to the Medical Director who shall issue a final decision within 2 days of the request.

Reporting of Appeals:

- The plan shall report quarterly to the Chairman on the number and the result of appeals under the plan.

CONNECTICUT

WORKERS' COMPENSATION COMMISSION

Utilization Review Company minimum standards for compliance with C.G.S. §31-279 and Administrative Regulations §31-279-10

Medical Care Plan: _____

Address:

Telephone: _____ **Toll Free:** _____

Business Hours (eastern time): _____

Contact Person: _____

Direct Telephone #: _____

Email address: _____

Utilization Review Company: _____

Address:

1. Please indicate compliance with the following standards pursuant to Connecticut General Statutes §31-279 and administrative regulations §31-279-10:

    - Not more than two (2) business days after receipt of all information regarding request for authorization of treatment, written notice shall be provided to the provider and employee of its determination regarding the recommended treatment.

    - In the case of an emergency condition, an employee or his representative shall be provided a minimum of twenty-four (24) hours following an admission, service or procedure to request certification and continuing treatment for that emergency condition before a utilization determination is made. If a determination is made not to provide such continuing treatment and the employee or his representative, the provider, or the employer requests a review of such determination, an expedited review shall be conducted by the medical director and a final decision rendered within two (2) days of the request for review.

    - Any written notice of a determination not to certify an admission, service, procedure or extension of stay shall include the reasons and the name and telephone number of the person to contact with regard to an appeal. The provider and the employee shall also be provided with a copy of the written review and appeal procedures.

    - The provider or the employee may, within fifteen (15) days of the written notice of determination, notify the plan of his or her intent to appeal a determination to deny payment for the recommended treatment.

    - Upon such appeal, at the request of the employee or provider, a practitioner in a specialty relating to the employee's condition for the purpose of reviewing the initial decision shall be provided

    - Within fifteen (15) days of the request for such review and submission of any further documentation regarding the review, the reviewing practitioner shall submit his opinion regarding such recommended treatment to the medical director of the medical care plan who shall, within fifteen (15) days thereafter, render a written decision regarding such treatment.

    - The employee, the provider or the employer may request a further review of the medical director's written decision; such request for further review shall be in writing and shall be submitted to the chief executive officer of the medical care plan within fifteen (15) days of the medical director's written decision.

    - The party requesting further review shall have an opportunity for a hearing if such party requests it in writing and may, at such party's expense, produce whatever written support or oral testimony it wishes at any such hearing.

    - Such hearing shall be conducted within fifteen (15) days of the written request.

    - The chief executive officer of the medical care plan shall make any final determination of such request for further review and may utilize an advisory committee to assist him in his determination.

    - The chief executive officer shall issue a final written decision on the request for further review as soon as practical but, in any event, within thirty (30) days of the later of the date of submission of the written request for such review or the date of conclusion of the hearing requested as part of such review.

    - The utilization review and appeal procedures personnel shall, at a minimum, satisfy the following standards:

        - Nurses and other health professionals other than physicians making utilization review recommendations and decisions shall hold current and valid licenses from a state licensing agency in the United States. Physicians making utilization review recommendations and decisions shall hold current and valid licenses in the State of Connecticut.

- Utilization review staff shall be generally available by toll-free telephone, at least forty hours per week during regular business hours.

- Each utilization review professional shall comply with all applicable state and federal laws to protect the confidentiality of individual medical records; summary and aggregate data shall not be considered confidential if it does not provide sufficient information to allow identification of individual patients.

- Each utilization review professional shall conduct its telephone and on-site information gathering reviews and hospital communications during the hospitals' reasonable and normal business hours, unless otherwise mutually agreed. Utilization review professionals shall identify themselves by name and by the name of their organization, if any, and, for on-site reviews, shall carry picture identification.

- No utilization review professional may receive any financial incentive based on the number of denials of certification made by such professional.

2. Indicate how the UR company is reimbursed for services:

3. Describe the professional liability coverage maintained by the UR company with respect to legal liability:

4. Indicate how reviewers are compensated:

5. Is the UR company currently accredited by URAC?

6. List all states where the company is currently licensed to perform UR:

7. Have any sanctions, fines, revocation, or restriction of licensure been imposed on the UR company by any regulatory agency? If yes, please explain:

CERTIFICATION STATEMENT

The undersigned, being duly sworn, hereby certifies on behalf of _____

_____

(company)

that the information provided herein is true and accurate, and further swears that by virtue of my position as _____ , I am vested with the

(officer)

authority to attest to these matters as well as to legally bind _____

_____

(company)

for any liability/action on account of any untruths, misrepresentations or inaccuracies contained herein.

Subscribed and sworn to before me

this _____ day of _____ , 20 _____

_____ Notary

Notary Public/Commissioner of the Superior Court

My Commission expires _____ , 20 _____

Signature of Executive Officer or Individual of Similar Rank

_____

Print Name of Signatory _____

Title _____

Implementation of
Safety & Health Connecticut Administrative Regulations
§ 31-40v-1 through § 31-40v-11

Safety Program Officers (SPOs) from the Workers' Compensation Commission are visiting Connecticut employers to assist them in complying with the State's recently effective safety and health committee regulations, pursuant to C.G.S. Section 31-40v-1.

Following the initial visit, a Safety Program Officer will return within 30 days to verify the employer's compliance with the regulations. At that time, the Safety Program Officer will review existing safety and health committees and/or programs. As directed by the Chairman, SPO's will perform a walk through of the employer's facility.

To ensure that employers are prepared for these meetings, please have the following information available:

- Completed inspection form (included in this information packet)
- A copy of safety committee meeting minutes from **one** committee meeting
- A copy of the posted roster containing committee member names and departments

To answer any of your questions or address any concerns you may have, the staff of the Commission's Safety and Health Services can be contacted at the Office of the Chairman, in Hartford, at (860) 493-1500.

INSPECTION FORM

DATE:

COMPANY NAME:

COMPANY ADDRESS:

COMPANY CONTACT: **TELEPHONE #**

BUSINESS TYPE: **PPO:** **YES** **NO**

TOTAL EMPLOYEES: _____

COMPANY SAFETY COMMITTEE: **YES** **NO**

TOTAL SAFETY COMMITTEE MEMBERS **_____**

TOTAL EMPLOYER MEMBERS **_____**

TOTAL EMPLOYEE MEMBERS **_____**

SAFETY COMMITTEE CHAIRPERSON **_____**

DATE SELECTED **_____**

DATE OF LAST SAFETY MEETING **_____**

DOES THE COMPANY HAVE A MASTER LIST OF SAFETY COMMITTEE MEMBERS? **YES** **NO**

IF YES, DOES THIS MASTER LIST CONSIST OF MEMBER NAMES AND THEIR DEPARTMENTS? **YES** **NO**

IS THIS LIST POSTED WHERE ALL EMPLOYEES HAVE ACCESS? **YES** **NO**

ARE SAFETY MEETING MINUTES KEPT? **YES** **NO**

IF YES, DO THESE MEETING MINUTES LIST THE ATTENDEES? **YES** **NO**

ARE ALL MEMBERS OF THE SAFETY COMMITTEE PAID FOR ALL TIME SPENT ON COMMITTEE ACTIVITIES? **YES** **NO**

DO SAFETY COMMITTEE MEETINGS INCLUDE:

ACCIDENT INVESTIGATIONS	**YES**	**NO**
SAFETY INSPECTIONS	**YES**	**NO**
SAFETY TRAINING PROGRAMS	**YES**	**NO**
HAZARD IDENTIFICATION AND/OR WORKPLACE EXPOSURE PROGRAMS	**YES**	**NO**
FOLLOW-UP PROCEDURES FOR OPEN SAFETY ITEMS	**YES**	**NO**
A WRITTEN AGENDA	**YES**	**NO**
A RECORD OF ALL SUGGESTIONS AND RECOMMENDATIONS	**YES**	**NO**

FREQUENCY OF SAFETY MEETINGS _____

DURATION OF SAFETY MEETINGS _____

ARE RESPONSIBILITIES ASSIGNED TO CORRECT SAFETY ISSUES? **YES** **NO**

HAVE ALL SAFETY COMMITTEE MEMBERS BEEN TRAINED IN THEIR RIGHTS AND RESPONSIBILITIES AS COMMITTEE MEMBERS?

YES **NO**

IF YES, HOW? _____

State of Connecticut Workers' Compensation Commission

Workers' Compensation Medical Care Plan

Employer Participation Form

Plan Sponsor _____

Name of Employer _____

Subsidiary _____

or

_____

D/B/A

(circle one) _____

Business Location(s) _____

_____

_____

Nature of Business _____ Total Number of Employees _____

If more than one business location, attach addresses and number of employees at each site.

Name and Title of Employer Representative _____

Phone ( ) -

Signature of Employer Representative _____

Current Workers' Compensation Carrier _____

(please indicate if authorized self-insurer)

Policy No. _____ Policy Term _____

Claims Office Location _____

_____

Plan Participation

1. Are any of your employees covered by a collective bargaining agreement?

   Yes _____ No _____

   If YES, include a statement that the Employer's participation is not in violation of any collective bargaining agreement, a copy of which will be made available to the Chairman upon request.

2. Has the Employer agreed to the performance of all obligations as outlined in the original Plan Application?

   Yes _____ No _____

   If NO, please attach a detailed description of any Employer responsibilities which have been amended by a client-sponsor contract.

3. Attach a copy of Approved Health & Safety Committee Certificate *(employers of 25 or more)*.

4. Attach a description of the financial arrangements between Plan and Employer *(CONFIDENTIAL)*.

5. Attach a copy of the plain language explanation to be distributed to employees.

6. Attach a description of the Modified/Light Duty Work Program *(employers of 50 or more)*.