PRIME HEALTH SERVICES

CASE MANAGEMENT

POLICIES AND PROCEDURES

PRIME HEALTH SERVICES

Introduction

Prime Health Services, Inc. (PHS) offers its Texas HCN clients access to a comprehensive case management program that assures quality patient care as well as optimal client savings. Depending on each client's needs, the case management program can be extensively customized and utilized. Alternatively, some clients may wish to utilize their internal case management program while other clients may have a standing relationship with another case management firm. In any case, PHS shall work with each client accessing our Texas HCN not only to accommodate their specific needs, but also to ensure our oversight of the individual programs and client relationships as required under the Texas HCN regulations.

For all Treatment and Disability Guidelines under our Texas HCN, PHS references the evidence-based criteria of the UniMedivance program, which is produced and maintained by UniMed Direct, Inc. With its headquarters located in Texas, UniMed Direct is a national medical cost containment company performing various UR services, including: prospective review (preauthorization), concurrent review, and retrospective review.

CASE MANAGER REQUIREMENTS

Case managers work with providers, employees, doctors, and employers in order to facilitate cost-effective health care and employees' efficient return-to-work. The case management program consists of experienced case managers, who must be certified in one or more of the following areas:

- Case management
- Case management administration
- Rehabilitation case management
- Continuity of care
- Disability management
- Occupational health

Note: *In accordance with Texas Labor Code §413.021(a), a claims adjuster may not serve as a case manager.*

The case manager's certifying organization (e.g., the Commission for Case Manager Certification) must be accredited by an established accrediting organization, including the National Commission for Certifying Agencies (NCCA), the American Board of Nursing Specialties, or another national accrediting agency with similar standards.

The case managers are fully equipped to adequately refer patients to in-network providers in order to generate the best patient care and Early Return to Work (ERTW)

while also producing the highest savings for our clients. Case managers successfully accommodate an ERTW through a variety of methods, which include:

- Maintaining active communications with the employer, client, provider, and injured employee;
- Assessing treatment plans, functional abilities, and medical and ERTW barriers;
- Establishing a specific plan to facilitate a medical recovery and ERTW; and
- Channeling injured employees to network providers whenever possible.

CASE MANAGEMENT FORMS AND PROCEDURES

Form 1: Standard Initial Report Form

In completing the Standard Initial Report, the case manager must make attempts to contact the patient within 24 hours of an initial injury. Within seven (7) days following an initial injury, the case manager must contact each of the parties involved. Case managers should prioritize initial communication efforts by contacting the claimant first, the employer second, and then the provider (PT, MD, DO, etc.). If the case manager is unable to contact all necessary parties within this time period by phone, then a certified letter must be sent to the claimant along with continuing efforts to contact the claimant by phone. Case managers should include additional information in the Initial Report that explains any difficulties encountered when making this initial contact.

Case managers should contact the employer to conduct a Job Analysis, which may require an on-site employer visit (determined on a case-by-case basis), to best evaluate the circumstances the employee will encounter upon his / her return to work.

All heading information must be documented in the Initial Report, and all pertinent claimant information (DOB, social security number, address, phone, etc.) should be verified during the initial interview. Case managers must record the date of the initial incident, which should coincide with the dates provided on any invoices received. Additionally, diagnosis codes must be specifically recorded along with any treatment modifications made during the course of treatment as the case develops.

The Initial Report should be clear and concise, generally not to exceed two (2) pages in length. The case manager should make best efforts to make such report accessible to clients within five (5) business days. Case Managers should include the following sections:

Medical Summary: The Medical Summary should include pertinent information and give the reader an overview of the medical status of the patient.

The Plan: The Plan details the steps being taken to accommodate the employee's ERTW and case managers should include the following:

- Actions to be taken for and on behalf of the patient over the next 30 days.
- Recommendations made in conjunction with the treating provider on behalf of the patient to show the direction of the patient's care.
- Detailed steps to be taken by the case manager to keep such care on track for ERTW, and such steps should be numbered according to their importance.
- Case manager should make recommendations—tailored to each case—for keeping it on track for ERTW. Recommendations should indicate the following:
    - **Who** will be contacted in order to complete the action?
    - **What** will the case manager do?
    - **When** will this act occur?
    - **Where** will this act occur?
    - **Why** is this action being taken?
- Case managers should not include recommendations unless they are absolutely sure the recommended act can be performed in the time provided.
- Case managers must indicate whether their recommendations require prior approval from the client and must obtain such approval before completing the recommendation. Receipt of approval must be recorded in subsequent reports.

The Narrative: The Narrative should expand on the information included in the Medical Summary and should present specific information regarding the case. The case manager should always include information under the following four (4) specific sections: Medical, Vocational, Financial and Behavioral (all four (4) detailed below).

Section 1: Medical – Case managers should include the following information:

- Claimant's perception of their injury, current medical status, and treatments he / she has received since their injury.
- Information gathered from communications or meetings with treating provider.
- Identification of any pre-existing injuries or other medical problems.
- Case manager should never solicit information regarding how the injury occurred. Claimant may offer this information, but it should <u>not</u> be included in the report. A simple notation that "Claimant was injured on [date]" will suffice.
- Case managers should not repeat information included in the medical reports.

- Claimant's understanding of his / her current medical status and whether it coincides with information presented in the medical reports.

Section 2: Vocational – Case managers should include the claimant's educational history (e.g., high school, GED, vocational school, college) as well as the following:

- Claimant's vocational history and / or military service.
- Previous job experience (which may be beneficial in developing the transferable skills list that can assist in re-training efforts).
- Claimant's perception of his / her pre-injury job responsibilities, as well as similar information from the employer.
- Whether claimant's description of his / her job coincides with the employer's description. Determine the reasons for any discrepancies.

Section 3: Financial – Case managers should assess a claimant's financial status, including income and current monthly expenses as well as reports of the following:

- Claimant's perception of how this injury has affected his / her financial status.
- Identify what impact claimant's status may have on his / her recovery. Is there a financial incentive for the claimant to return to work?

Section 4: Behavioral – Case managers should include specific details regarding claimant's behavior and cooperation as well as noting whether his/her family was supportive of the claimant. Additionally, case managers should note the following:

- Information regarding the claimant's attitude regarding the injury.
- Identify any behavioral factors that may influence the claimant's recovery.
- Document what is observed in terms of claimant and family behavior.

Form 2: Standard Progress Report

Case managers should routinely update the interested parties using the *Standard Progress Report*, which should be 1-2 pages in length and submitted each week after the claimant is contacted, or no less than once every 30 days. Standard Progress Reports should include:

- Notes of any heading changes which may have occurred since the last report.
- Review of previous report and recommendations.
- Notes of all recommended actions that have been accomplished. (If a recommended action has not been accomplished, address the reason why it has not.)
- Update any changes in claimant's information and diagnosis.
- There should be a brief Medical Summary that includes only pertinent information.

- Repeat the steps for writing the Plan (see above under Standard Initial Report).
- Progress reports should be one page and brief (Header, Medical Summary and Plan).

Form 3: Standard Closure Report

The Standard Closure Report should be one page (Header, Medical Summary and Action Taken). Case managers will use this report as the final written report when cases are closed, which occurs for a variety of reasons, including:

- Return to work (same employer or new employer)
- Same job/position or modified job/position
- Claimant at MMI
- Claimant (or attorney) non-compliance with rehabilitation
- Insurance company request for closure

Medical Summary: Case managers should specify the reasons and occurrences that led to its closure, while only including pertinent info since the last progress report.

Action Taken: Should be specific and individualized for each case and must include:

- Actions that have been taken throughout the case in order to reach its goals.
- Detail the steps taken in order to achieve the goals.
- Positive statements addressing case manager's interaction with the claimant.

Form 4: Job Analysis

The Job Analysis is generally conducted through an on-site visit to the employer or job site. In a situation where an on-site visit cannot be conducted, a Job Analysis may be conducted via telephone. When conducting an on-site Job Analysis, the case managers should tell the employer that they need to see the job being performed. If possible, the case manager should request permission to physically perform the job themselves, which better prepares the case manager for presenting the job's specific physical requirements. It is recommended to the case manager to bring a copy of the Job Analysis form so the employer are aware of the information being sought by the case manager during the on-site visit.

The Job Analysis should be scientific and factual. At the time of the on-site visit, case managers should clarify any discrepancies that exist between their observations on the job and what the claimant reported regarding their job duties.

The evaluation of each body movement should be specific to the claimant's injury. When reading a job analysis, the reader should be able to visualize the job being performed.

CASE MANAGEMENT PROGRAM COMPLIANCE AND LICENSURE

Professional Liability Insurance: In situations where case managers are considered independent contractors and not employees of PHS, case managers must have professional liability insurance in place and in good standing before working a case.

Licensure and Verification: Prior to case managers working cases on behalf of a client, PHS must verify their licensure and must assure compliance with applicable state rules and regulations. PHS verifies the licensure of case managers no less than annually.

Required State Forms: PHS assures that all forms utilized by case managers comply with state mandated forms and/or applicable regulations.

Billing Guidelines: All invoices should be mailed to PHS in conjunction with submitted reports. PHS or its client(s) will be responsible for reimbursing the case manager for services rendered within 30 days of receipt of the invoice.

EMERGENCY CARE AND OUT-OF-NETWORK REFERRALS

Emergency Care: In accordance with Texas Insurance Code §1305, an insurance carrier or payor that contracts with the HCN is liable for in-network healthcare provided to an injured employee for compensable injuries as well as for the following out-of-network care:

- Emergency care;
- Healthcare provided to an injured employee who does not live within the network's service area; or
- Healthcare provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network.

Out-of-Network Referral Process: If an injured employee's treating doctor requests a referral to an out-of-network provider for medically necessary healthcare services that are not available from network providers, the referral to an out-of-network provider must be approved, or denied, within the time appropriate under the circumstances but, under any circumstance, no later than seven (7) days after the date the referral is requested.

If the referral request is denied because the requested service is available from network providers, the employee may file a complaint in accordance with the network's complaint process. *TIC §1305.402 and 28 TAC §10.121*

If the referral request is denied because the specialist referral is not medically necessary, the employee may file a request for independent review. *28 TAC §10.104*

An injured employee is not required to comply with the HCN requirements until the employee receives PHS's Notice of Network Requirements; therefore, the employee cannot be required to treat within the PHS Texas HCN and cannot be required to select a network treating doctor prior to receiving such Notice from PHS.