Health Care Provider Panels List Defined

The PA Workers' Compensation Act gives employers the right to establish a list of designated health care providers. When the list is properly posted, injured workers must seek treatment for the work injury or illness with one of the designated providers for 90 days from the date of the first visit. Exceptions to the 90-day rule do exist, related in large part to collective bargaining agreements.

There are some specific guidelines provided in the rules and regulations for these lists:

- The employer must provide a clearly written notice to employee of the employee's rights and duties.
- The notice must be signed by the employee at the time of hire, whenever changes are made in the list, and at the time of injury.
- The list must contain at least six providers; three of the six providers must be physicians.
- Providers as defined in the Act are more than just physicians.
    - “Health care provider’ means any person, corporation, facility, or institution licensed or otherwise authorized by the Commonwealth to provide health care services, including, but not limited to, any physician, coordinated care organization, hospital, health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, psychologist, chiropractor, or pharmacist, and an officer, employee, or agent of such person acting in the course and scope of employment or agency related to health care services.
- Each provider's name, address, telephone number, and specialty must be included on the list.
- If a particular specialty is not on the list and the specialty care is reasonable and necessary for treatment of the work injury, the employee will be allowed to treat with a health care provider of his or her choosing. Martin v. WCAB (Emmaus Bakery), 652 A.2d 130, the employer may not direct the employee to any specific provider on the list.
- The employee may switch from one designated provider to another designated provider.
- Listed providers must be geographically accessible.
- Listed providers must contain specialties appropriate for the anticipated work-related medical problems of the employee.

- If employer's list of designated providers fails to comport with the Act and the regulations, the employee has the right to treat with a provider of his or her choice.

  Further details on the list of designated providers and its correct use are contained in Subchapter D, Sections 127.751 through 127.755 of the rules and regulations found on page 255 of the Workers' Compensation Act as revised and reprinted 2009.

If you are interested in becoming a WorkPartners' Health Care Panel Provider, please contact the Manager of Network Services at 1-800-633-1197.

Health Care Panel Provider's Responsibilities

If you have been selected as a WorkPartners' Health Care Panel Provider, expectations are as follows:

1) Panel Providers are required to see WorkPartners clients' injured workers in a timely manner, preferably within 24 hours of injury for acute injuries and within one week for specialty referrals that have already been stabilized by primary panel providers. The request may come from the employee, the employee's supervisor, or WorkPartners Claims Management.

2) Panel Providers will be required to communicate results of appointments directly to the WorkPartners Claims Management Service staff via e-mail or fax of a standardized work status form within 24 hours of the visit, or, preferably, the same day as the visit. A phone call is appreciated, but does not replace written documentation, which should include diagnosis, duty status w/restrictions (if needed), and follow-up date and time.

   UPMC WorkPartners centralized phone number: 1-800-633-1197
   UPMC WorkPartners' fax number: 412-667-7100 (UPMC and University of Pittsburgh); 412-667-7110 (City of Pittsburgh); 412-667-7111 (County of Allegheny)

3) Panel Providers should always consider that WorkPartners can facilitate modified/transitional work assignments and that physical capabilities should be determined at each appointment to allow us to keep our injured employees working safely. **If an employee needs a short period of complete disability, the Panel Provider must notify WorkPartners of such AND re-evaluate the employee within a 3-day period, unless the disability is related to a post-operative course of recovery.**

Coordination of Care

Specialist Referral Guidelines:

Referrals must be made to WorkPartners' approved specialists; some panels contain specialist information and some do not. If your panel does not contain specialist information, please contact WorkPartners Claims Management for authorization prior to making a referral. This will ensure timely access to specialists, as well as timely return of findings to Primary Panel physician.

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Diagnostic Referral Guidelines:

Panel Providers will be responsible for scheduling injured employees for follow-up appointments and/or ancillary services before the employee leaves the premises. If an ancillary service, such as an MRI, is needed, please call the number listed above to speak with a claims representative prior to scheduling the appointment. Most MRI scheduling should be done using the Raytel Imaging Network at 1-800-453-0574 or the UPMC MRI program (UPMC employees only at this time) at 412-683-7500. For UPMC Mercy, use own MRI service.

The features of our MRI program are as follows:

- Timely access to appointment, usually within 24-48 hours of notice of need
- Report to both treating provider and payer
- Preferential pricing inclusive of both technical and professional components

Utilization of our program enables injured workers to access the recommended diagnostic testing in the most timely and cost-effective manner.

Physical Therapy Network and Guidelines:

WorkPartners serves as the premier physical therapy network manager and single point of contact for southwestern Pennsylvania employers who have injured employees requiring rehabilitation as part of their overall occupational treatment plan. The benefits of our program include timely access to quality professionals experienced in occupational rehabilitation, convenient geographic coverage inclusive of Allegheny and surrounding counties, and cost containment tools that provide preferential pricing below the Pennsylvania Work Comp Part B Fee schedule.

WorkPartners also provides support to the "safe but early return to work" philosophy by enhancing the communication between rehabilitation staff and treating physician.

Health Care Panel Provider Information

Our integrated system provides centralized scheduling, first evaluations with in 72 hours of referral, and reporting capabilities to support case and claims management that include:

- Weekly reports that accurately reflect information such as dates of service and number of visits to present
- Monthly closed case reports
- Monthly compliance reports
- Monthly savings analysis

WorkPartners Physical Therapy Network comprises Centers for Rehab Services and Concentra Medical Centers; each maintains a quality assurance program to support this network. This QA program incorporates a formal quarterly reporting of quality and outcomes at the client's request, as well as an ongoing day-to-day communication with respect to any issues that may need immediate attention as directed by WorkPartners' clients (employers, insurers, case management companies). Cases that exceed 12 visits can be flagged and information provided to the client with regard to the injured worker's overall therapy progression, any red flags or problems noted by the therapist, and reason for additional therapy felt to be beneficial.

All WorkPartners health care provider panels include rehabilitation service panel providers; physical and occupational therapy referrals are to be made to panel providers in all cases needed, unless approval is received from our claims office to seek services outside the designated panel list (1-800-633-1197).

Pharmacy Guidelines:

WorkPartners utilizes Integrated Prescription Solutions (IPS) as its pharmacy benefits manager. Through IPS, injured workers have access to many conveniently located pharmacies at which they can fill their work-related prescriptions with no out-of-pocket expense, for an average savings to the employer of 17 to 20 percent below the Pennsylvania Fee Schedule.

All WorkPartners Health Care Provider Panels include pharmacy information.

Medical Records Documentation:

Provider documentation is extremely important to the overall management of a workers' compensation claim. Providers should evaluate the overall clinical picture within the context of the reported mechanism of injury and offer opinion if the objective findings correlate with the subjective complaints.

A provider should evaluate an injured worker's functional ability at each appointment and, if the worker is not able to be returned to his/her pre-injury job, then determine physical capabilities that allow an employer to evaluate whether transitional or modified duty work is available.

Health Care Panel Provider Information

The following documentation is required to be sent to WorkPartners within 24 hours of an appointment, or on the same day, if possible:

- Diagnosis
- Duty status
- Physical capabilities or restrictions if unable to return to the pre-injury job
- Treatment recommendations
- Follow-up appointment date/time

All office notes need to be submitted with the billing for consideration of reimbursement. Any billing received that does not have any documentation will be returned to the provider. If documentation does not support the level of service billed, the bill may be denied in full or downcoded as per the PA Workers' Compensation medical cost containment amendment.

Forms:

Please refer to WorkPartners' Physician Encounter Forms for our self-insured and commercial business lines**.**

Provider Credentialing

If you are credentialed through UPMC Health Plan, the following process will be applied. If you are not a credentialed provider through UPMC Health Plan but are participating or would like to participate in the WorkPartners network, please call 1-800-633-1197.

The provider credentialing process involves several steps: application, primary source verification, on-site evaluation, notification, and a Credentials Committee review.

Application

Physicians may request an application to be credentialed as a UPMC Health Plan provider through Provider Services at 1-866-918-1595. According to Health Plan guidelines, network providers must be re-credentialed every 2 to 3 years.

The provider should fill in all of the requested information, sign, and date the application, and return it with any requested documents for initial processing to:

UPMC Health Plan
Network Management
One Chatham Center
112 Washington Place
Pittsburgh, PA 15219

If the provider is a member of a Health Plan network physician hospital organization (PHO), the provider should return the completed application to the respective PHO for processing.

Closer Look at the Application Process

The Credentialing Department checks the application for completeness. If documents or other information is missing, the credentialing staff will return the application with a request that the missing information be submitted. Providers must provide a signature reflecting the new date of completion.

Primary Source Verification

The Credentialing Department contacts each primary source to verify the following credentials:

Board certification
Malpractice insurance coverage and history of liability claims
Medicare and Medicaid sanctions
Residency or medical school only if not board-certified (highest level of education or training must be verified)
Sanctions, restrictions, or suspensions of a state license
Status of staff privileges at a network Health Plan hospital(s)
Valid DEA or CDS certification
Valid, unrestricted license to practice in state(s) in which the practice resides
Work history — this does not require primary source verification, although gaps of 6 months must be reviewed with the practitioner and gaps of 1 year need to be clarified in writing by the practitioner for inclusion in the credentialing file.

On-Site Evaluation

A clinical review nurse will contact high-volume specialists to arrange an on-site evaluation of practice site(s) and medical record documentation. The following Health Plan standards will be assessed:

Adequacy of waiting room and exam room space
Availability of appointments
Emergency care and CPR certification
Hazardous waste elimination
Medical equipment management
Medical record documentation
Medication administration
Physical accessibility, availability, and appearance of practice site(s)
Radiology, cardiology, and laboratory services (if applicable)

Notification

Once all information is complete, including primary source verification and office site review (if applicable), the Credentialing Department reviews and compares all information on the application to the primary source data. If any discrepancies are noted,

the practitioner is notified in writing and has 2 weeks to forward the correct information in writing to the Credentialing Department supervisor.

In addition, a practitioner has the right to review the information submitted in support of his or her application. If the practitioner discovers erroneous information on the application, the practitioner has the opportunity to correct this information before the Credentials Committee reviews it. The practitioner must initial and date the corrected information.

Upon request, a practitioner also has the right to request information regarding the status of his/her credentialing/re-credentialing application.

Credentials Committee Review

Completed credentialing files are then presented to the Credentials Committee for review and deliberation.

A welcome letter and packet are sent to practitioners once they are approved as providers in the UPMC Health Plan provider network.

Practitioners will be notified in writing if they are denied credentialing status for some reason. In the event that a practitioner wishes to appeal a credentialing denial decision, the request must be submitted via a letter addressed to the chairperson of the Credentials Committee.

Re-credentialing Process

All practitioners must be re-credentialed within 2 to 3 years of the date of their last credentialing cycle. The re-credentialing process is the same basic process as that for credentialing, except that practitioners also are evaluated on their professional performance, judgment, and clinical competence. Criteria used for this evaluation may include, but not be limited to, the following:

Compliance with the Health Plan's policies and procedures
Health Plan sanctioning related to utilization management,
administrative issues, or quality of care
Member complaints
Member satisfaction survey
Participation in quality improvement activities
Quality-of-care concerns

Applications for reappointment are forwarded to the practitioner about 6 months before the practitioner's re-credentialing