

Risico Total Managed Care Provider and Vendor Manual

PROPRIETARY INFORMATION

Risico has developed this manual for providers and vendors participating in our client customized Medical Provider Networks (MPN) and Alternative Dispute Prevention and Resolution (ADR) Program. The role of our providers and vendors is to provide the right treatment at the right time, based on clinical judgement, evidenced based guidelines and appropriate medical practice.

What is a MPN and/or ADR Medical Provider List?

They are a group of healthcare providers, including but not limited to any physician, hospital, urgent care facilities, occupational care facilities, physical therapy facilities, other ancillary medical service providers, persons employed by such provider, entities that provide services under the provider's tax identification number(s), or any other health care provider, which have entered into an agreement directly or indirectly with Risico Total Managed Care to participate in our client customized MPN or ADR Programs and/or PPO to provide health care services to Risico Total Managed Care Network(s) and the MPN, ADR and/or PPO covered employees.

DEFINITIONS

- ✓ **"ACOEM Guidelines"** means the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines, Second Edition.
- ✓ **"Ancillary Medical Service"** means covered service necessary to diagnosis and treatment of the covered injured employees, including, but not limited to, ambulance, ambulatory or day surgery, durable medical equipment, imaging service, laboratory, pharmacy, physical or occupational therapy and other covered service customarily deemed ancillary to the care furnished by primary care or specialist physicians or providers.
- ✓ **"Ancillary Services"** means any provision of medical services or goods allowed in Labor Code Section 4600 by a non-physician, including, but not limited to interpreter services, physical therapy, orthotic and prosthetic devices, crutches and pharmaceutical services.
- ✓ **"Covered Employee"** means an employee or former employee whose employer has ongoing workers' compensation obligations and whose employer or employer's insurer is using a Medical Provider Network for the provision of medical treatment to injured employees unless:
 - The injured employee has properly designated a personal physician pursuant to Labor Code Section 4600(d) by notice to the employer prior to the date of injury, or;
 - The injured employee's employment with the employer is covered by an agreement providing medical treatment for the injured employee and the agreement is validity established under Labor Code Section 3201.5, 3201.7 or 3201.81.
- ✓ **"CURES"** means Controlled Substance Utilization Review and Evaluation System.
- ✓ **"Days"** shall mean calendar days unless otherwise specifically provided. Calculation of time will be consistent with the calculations set forth in California Civil Code Section 10.
- ✓ **"Duly Licensed"** means authorized to do business under any State or Federal law as well as maintaining proper licensure and certification as hereinafter required:
 - Business Associate agrees that it shall make its internal practices, books, and records relating to the use and disclosure of PHI received from Employer, or created or, received by Business Associate on behalf of Employer, in compliance with HIPPA's Privacy Rule, including, but not

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limited to the requirements set for in Title 45, CFR sections 160 and 164. Business Associate shall make its internal practices, books and records relating to the use and disclosure of PHI

received from Employer, or created or received by the Business Associate on behalf of the Employer, available to the United States Department of Health and Human Services (Secretary) upon demand.

- Business Associate shall cooperate with the compliance and investigation reviews conducted by the Secretary. PHI access to the Secretary must be provided during the Business Associate's normal business hours, however, upon exigent circumstances access at any time must be granted. Upon the Secretary's compliance or investigation review, PHI is unavailable to Business Associate and in possession of a Subcontractor, it must certify efforts to obtain the information to the Secretary.
- ✓ **"Durable Medical Equipment (DME)"** means equipment that can be used repeatedly, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury and is appropriate for use at home. Examples include hospital beds, wheelchairs and oxygen equipment.
- ✓ **"Employee"** means a covered employee as defined in Title 8 California Code of Regulations Sections 9767.1(a) (2).
- ✓ **"Employer"** means a California employer who either directly or indirectly through a TPA, self-administered entity, employer association, or other entity, has contracted with Risico Total Managed Care for the provision of health services to employees who have suffered work related illnesses or injuries.
 - **Employer** also means a self-insured employer, the Self-Insurer's Security Fund, a group of self-insured employers pursuant to Labor Code Section 3700(b) and as defined by Title 8, California Code of Regulations, section 15201(s), a joint powers authority, or the State.
- ✓ **"Entity that provides physician network services"** means a legal entity employing or contracting with physicians and other medical providers or contracting with physician networks, and may include but is not limited to third party administrators and managed care entities, to deliver medical treatment to injured employees on behalf of one or more insurers, self-insured employers, the Uninsured Employers Benefits Trust Fund, the California Insurance Guaranty Association, or the Self-Insurers Security Fund, and that meets the requirements of Labor Code 4616 et seq., and corresponding regulations.
- ✓ **"Injury"** means an illness or injury arising out of or in the course of the worker's employment for which an Employer is liable under the Workers Compensation Law.
- ✓ **"Insurer"** means an insurer admitted to transact workers' compensation insurance in the State of California, California Insurance Guarantee Association, or the State Compensation Insurance Fund.
- ✓ **"Medical Treatment Utilization Schedule (MTUS)"** means the evidence based treatment guidelines adopted by the California Department of Workers' Compensation as recommendations for the treatment of injured workers. (Available on the CA Government DWC website for reference).
- ✓ **"Payor"** means a self-insured employer, TPA, insurance company, health services plan, trust, non-profit facilities services plan or any government unit or other entity which has an obligation under the Labor Code of the State of California to provider medically necessary and appropriate medical services to cure or relieve the effects of an industrial injury.

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- ✓ **“Physician Covered Service”** means those medical services which are Workers’ Compensation Health Services and which are Medically Necessary services.
- ✓ **“Primary Treating Physician” (PTP)** means a primary treating physician within the Medical Provider Network that is primarily responsible for managing the care of an employee and as further defined by section 9785(a)(1).
- ✓ **“Provider”** means a physician as described below:
 - LC Section 3209.3: **“Physician”** includes physicians and surgeons holding an M.D. or D.O. degree, psychologist, acupuncturist, optometrists, dentists, podiatrist, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law. “Psychologist” means a licensed psychologist with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology pursuant to Section 2914 of the Business and Professions Code, and who either has at least two years of clinical experience in a recognized health setting or has met the standards of the National Register of the Health Service Providers in Psychology. “Acupuncturist” means a person who holds an acupuncturist’s certificate issued pursuant to Chapter 12 (commencing with Section 4925 of Division 2 of the Business and Professions Code.
 - LC Section 3209.5: Medical surgical, and hospital treatment including nursing, medicines, medical and surgical supplies, crutches, and apparatus, includes but is not limited to services and supplies by physical therapists, chiropractic practitioners, and acupuncturists, as licensed by California state law within the scope of their practice as defined by law.
- ✓ **“Specialist”** means an MPN, ADR and/or PPO Provider who is a Doctor of Medicine or a Doctor of Osteopathy who has successfully completed a postgraduate training program in a specialty or subspecialty recognized by the American Board of Specialties, other than pediatrics, OB/GYN, family practice, or general internal medicine.
- ✓ **“Treating Physician”** means any physician within the MPN, ADR and/or PPO Provider applicant’s MPN, ADR and/or PPO Provider other than the primary treating physician who examines or provides treatment to the employee, but is not primarily responsible for continuing management of the care of the employee.
- ✓ **“Workers’ Compensation Laws”** means the workers’ compensation and insurance laws of the State of California.

GENERAL AGREEMENT

- ✓ As a Risico client customized MPN or ADR participating provider, you shall deliver medically necessary services to employer’s employees, consistent with the applicable workers’ compensation laws. The provider agrees to accept the payment as specified in the Agreement or at Official Medical Fee Schedule, whichever is applicable. Provider shall utilize Risico preferred providers to provide medically necessary services outside of the specialty area of provider.

PROVIDER SERVICES

- ✓ The Primary Treating Physician is responsible for initial care to the injured employee and assessing whether further care may be necessary. The Primary Treating Physician is responsible for managing disability as well as the treatment course throughout the duration of the claim including post referrals to specialists.

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- ✓ Specialists shall provide the Primary Treating Physician their recommendations as it pertains to disability as well as their treatment course.
- ✓ Risico reserves the right to use Risico approved MPN, ADR and/or PPO Providers for all recommended surgeries as well as Risico approved MPN, ADR, and/or PPO Providers for in-patient or out-patient recommended surgeries or procedures and/or ancillary services. All Medical providers within the Risico client customized MPN, ADR and/or PPO must adhere and comply with the Risico MPN, ADR and/or PPO Medical Provider Guidelines as follows:
 - If the covered injured employee is requesting an initial or subsequent appointment with the Primary Treating Physician(s)/Specialist Physician(s)/Medical Provider(s) so he/she can return to work, the Primary Treating Physician(s)/Specialist Physician(s)/Medical Provider(s) shall accommodate an appointment within five (5) business days of such request.
 - When conservative care of a covered injured employee exceeds ninety (90) days, the Primary Treating Physician(s)/Specialist Physician(s)/Medical Provider(s) shall contact the Claims Adjuster or Ombudsperson if within the ADR Program to discuss diagnosis, specialist referral, and overall treatment plan.
 - All Primary Treating Physician(s)/Specialist Physician(s)/Medical Provider(s) shall complete all necessary reports timely and within the prescribed regulatory requirements.
 - All Primary Treating Physician(s)/Specialist Physician(s)/Medical Provider(s) who request an opportunity to review records of a covered injured employee, prior to agreeing to see the patient, shall not be reimbursed for the review, and must provide an answer as to whether or not they will accept the patient within five (5) working days of the request
 - The Primary Treating Physician(s)/Specialist Physician(s)/Medical Provider(s) shall adhere to checking CURES before prescribing controlled substances.
 - Primary Treating Physician(s)/Specialist Physician(s)/Medical Provider(s) must notify the Claims Adjuster for any over-the-counter medication dispensing, and/or outside first fill protocols per client. Providers should not be dispensing prescriptions on-site.
 - All Primary Treating Physician(s)/Specialist Physician(s)/Medical Provider(s) shall fully complete, and follow the State Regulatory Requirements for completing the Request for Authorization (RFA) request for treatment. All Primary Treating Physician(s)/Specialist Physician(s)/Medical Provider(s) shall only utilize the RFA process for treatment requests that meet the requirements of the State Regulations.
 - All Primary Treating Physician(s)/Specialist Physician(s)/Medical Provider(s) must agree to complete a PR-4 when necessary and comply with the State Regulations (9785); PR-4 shall be reported within twenty (20) days, per Regulation 9785.
 - All Primary Treating Physician(s)/Medical Provider(s) must agree to set appointments for new or referred covered injured employees within three (3) working days of such request.
 - All Specialist Physician(s)/Medical Provider(s) must agree to set appointments for a referred covered injured employee within twenty (20) working days of such appointment request.
 - Primary Treating Physician(s)/Specialist Physician(s)/Medical Provider(s) must agree to have the covered employee examined within a timely manner of the set appointment time; wait times in

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excess of forty-five (45) minutes will require written explanation to the Third Party Administrator, explaining the reason for the delay and efforts to avoid future occurrences.

- All Primary Treating Physician(s)/Specialist Physician(s)/Medical Provider(s) must agree to address return to work status at each office visit. This includes consideration for both modified and/or alternate work. Estimates for duration of work restriction(s) and anticipated MMI date shall be included in all PR-2 reporting.
- Primary Treating Physician(s)/Specialist Physician(s)/Medical Provider(s) are not to rely on information from the patient indicating that modified/alternate work is not available. If additional information, such as a job description, would be helpful, it is expected that the Third Party Administrator will be contacted with a request for additional information is necessary to assist with the assignment of work restrictions. Statements such as “I won’t be able to lift anything” should be challenged with follow up questions.

Work restrictions shall be as detailed as possible. Patients are to be reminded that restrictions are to be followed at home as well.

Any change in work status requires a face to face office visit with the patient. Change or extension of a patients work restriction is prohibited by telephone, fax or email communication from the patient requesting change(s).

If the employee is released to any type of work while being prescribed medication, reporting must address any affect(s) medications may have on work status.

The written information must include the following:

- Injured employee’s name, address and social security number;
 - Name of employee’s work department;
 - Injured employee’s complete medical history as obtained and reviewed by physician;
 - The physician’s objective findings on the examination;
 - The planned course, scope, frequency and duration of the treatment;
 - Detailed work restrictions and a planned return-to-work date;
 - If medication is prescribed, note whether it will make the injured employee drowsy and provide clear documentation if only prescribed for hour of sleep.
 - Maximum Medical Improvement (MMI) ratings, if appropriate or functional capacity of the injured employee.
- ✓ All reports shall be submitted using the appropriate required form(s) including:
- Doctor’s First Report of Occupational Injury or Illness (5021 REV 5 2015) within five (5) days of initial examination, for every occupational injury or illness.
 - Primary Treating Physicians Progress Report (DWC Form PR-2 REV 2015). A narrative format is acceptable and shall be legible, but it must be entitled “Primary Treating Physician’s Progress Report” in bold faced-type and must contain the same information in the same order as the DWC Form PR-2.
 - Primary Treating Physician’s Maximum Medical Improvement (MMI) report (DWC Form PR-3 REV 2015). This form is required to be used for ratings and prepared pursuant to the 1997 Permanent Disability Rating Schedule. It is designed to be used by the Primary Treating

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Physician to report the initial evaluation of permanent disability to the claims administrator. (This form should not be used by a Qualified Medical Evaluator (QME) or Agreed Medical Evaluator (AME) to report a medical-legal evaluation.

- Primary Treating Physician's Maximum Medical Improvement (MMI) report (DWC Form PR-4 REV 2015). This form is required to be used for rating prepared pursuant to the 2005 Permanent Disability Rating Schedule and the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (5th edition). It is designed to be used by the primary treating physician to report initial evaluation of permanent impairment to the claims administrator. (This form should not be used by a Qualified Medical Evaluator (QME) or Agreed Medical Evaluator (AME) to report a medical-legal evaluation.
- Physician's Return-to-Work & Voucher Report for injuries on or after 1/1/13.
 - Who is responsible for filling out this form? The first physician (primary treating physician, Agreed Medical Evaluator (AME), or Panel Qualified Medical Evaluator (PQME) who finds that the disability from all conditions for which compensation is claimed has become permanent and stationary (P&S) (or has reached maximum medical improvement (MMI)) and finds that the injured caused permanent partial disability.
 - What is the purpose of this form? The purpose of the form is to fully inform the employer of the work capacities and activity restrictions resulting from the injury that are relevant to potential regular work, modified work, or alternative work. The information contained on the form is for voucher purposes and is not considered in any permanent impairment rating or any permanent disability indemnity.
 - Is this a mandatory form? This is a mandatory attachment to the first medical report finding that the disability from all conditions for which compensation is claimed has become permanent and stationary (P&S) or has reached maximum medical improvement (MMI) and that the injury has caused permanent partial disability. This form should be attached to a comprehensive medical-legal evaluation and does not replace such comprehensive medical-legal evaluations.
 - When does the form need to be completed? This form does not need to be completed until all conditions for which compensation is claimed have become permanent and stationary (P&S) or has reached maximum medical improvement (MMI).

If the employer or claims administrator has provided you with a job description providing physical requirements of the employee's regular work, proposed modified work, or proposed alternative work, the physician will evaluate and describe in the form whether the work capacities and activity restrictions are compatible with the physical requirements set forth in that job description. The bottom portion of the form does not need to be completed if the physician has not been provided with a job description.

- Completing the employee's work restrictions: The physician should indicate work restrictions in terms of how many hours a particular activity is restricted during an 8-hour work day. For hand restrictions, the physician should indicate whether the restrictions are for the right hand, left hand or both.

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Other restrictions can include chemical exposure, psychiatric restrictions, use of equipment, or any other restrictions.

Copies of required forms may be obtained from the Department of Workers' Compensation (DWC) website at: <http://www.dir.ca.gov/dwc/forms.html>

Or

https://www.dir.ca.gov/dwc/DWCPropRegs/SJDB_Regs/DWCForm10133.36.pdf

Information about the AMA Guidelines can be obtained by accessing: www.ama-assn.org

- ✓ Under California Labor Code Section 4628, providers may be requested to submit medical-legal reports. When requested, providers shall provide medical-legal reports in a timely manner. The purpose of these reports is to provide an objective evaluation of the employee's medical condition for a contested claim. At minimum, reports shall include the following:
 - Injured employee's medical condition at time of the evaluation;
 - The cause and treatment of the medical condition;
 - The existence, nature, duration or extent of total temporary disability (TTD), partial temporary disability (PTD) and/or other disability caused by the injured employee's medical condition; and
 - The employee's medical eligibility for Supplemental Job Displacement Benefit (SJDB) voucher.
- ✓ All Primary Treating Physician(s)/Specialist Physician(s)/Medical Provider(s) must agree to perform Peer-to-Peer reviews regarding covered injured employees Utilization Review activities, other treatment requests and Risico Medical Director requests. Since Utilization Requests are time sensitive per the State Regulations, all request for return calls shall be returned immediately, and in all cases within twenty-four (24) hours.
- ✓ Primary Treating Physician(s)/ Medical Providers(s) shall make referrals to specialists as recommended by MTUS (including ACOEM) or other evidence based guidelines generally recognized by the national medical community and that are scientifically based. All requests for referrals to specialists:
 - Must be pre-authorized by Risico Claims Management or nurse case manager prior to the referral; and
 - Requires rationale why the specialist referral is medically necessary to evaluate and/or diagnose the medical condition of the injured employee; and
 - Shall be made within the Risico client customized MPN or ADR Medical Provider List unless there is an extenuating medical reason why a physician specialist uniquely qualified to evaluate or manage the specific condition of the injured employee can't be identified within the Risico client custom MPN or ADR Medical Provider List.
- ✓ The Primary Treating Physician(s)/Specialist Physician(s)/Medical Provider(s) shall adhere to the special instructions of Risico's clients. (See Client Specific Prior Authorization Addendums)

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- ✓ Provider shall provide medically necessary services in an efficient and timely manner and consistent with applicable workers' compensations laws. This includes, but is not limited to:
 - Treatment for Occupational injuries within the licensure and experience of Providers which treatment is reasonably required to cure or relieve the effects of an Occupational injury in accordance with Workers' Compensation laws;
 - Determinations of medical treatment decisions and recommendations for services subject to Employer's utilization review processes;
 - Preparation of all reports and recordkeeping required of a treating provider under Workers' Compensation laws and within seventy-two (72) hours after treatment or service visit; and
 - Referrals for institutional and professional services that the treating physician deems medically necessary, provided that referrals to physicians, practitioners, medical service providers, and ancillary service providers are consistent with the Agreement. Risico Claims Management, Risico Total Managed Care, Claims Adjuster or the Nurse Case Manager shall be called for referrals that involve the following unless listed under clients Prior Authorization Guidelines, where applicable.
 - Diagnostic Testing;
 - Durable Medical Equipment (DME)
 - Home Health Services; or
 - Physical/Occupational Therapy

- ✓ Injured employees are entitled change physicians within the MPN or ADR at any time after the initial medical evaluation with a Risico client customized MPN or ADR provider. Please advise Risico Claims Management if an injured employee requests a change of physician. The selection of a treating physician and any subsequent physicians shall be based on the physician's specialty or recognized expertise in treating the particular injury or condition in question.

- ✓ If the injured employee disagrees with either the **diagnosis** or **treatment** prescribed by you, they may ask for a second opinion from another doctor within the MPN or ADR Medical Provider List. If they want a second opinion, they must contact the MPN contact, ADR Ombudsperson or their claims adjuster and tell them they want a second opinion. The MPN contact, ADR Ombudsperson or their claims adjuster should give them at least a regional or full MPN or ADR Medical Provider List from which they can choose a second opinion doctor. To get a second opinion, they must choose a doctor from the MPN or ADR Medical Provider List and make an appointment. If within the MPN, they must do so within 60 days. They must tell the MPN contact or claims adjuster of their appointment date, and the MPN or claims adjuster will send the doctor a copy of their medical records. They can request a copy of their medical records that will be sent to the doctor. If within the ADR, they must tell the Ombudsperson of their appointment date, and the Ombudsperson will send the doctor a copy of their medical records.

If the injured employee in within an MPN and does not make a second opinion appointment within 60 days of receiving the regional area list, they will **not** be allowed to have a second or third opinion with regard to the disputed **diagnosis** or **treatment** of this treating physician if they are in the MPN.

If the second-opinion doctor feels that their injury is outside the type of injury he or she normally treats, you shall notify the employer or insurer and the injured employee. They will get another list of MPN or ADR doctors or specialists so they can make another selection.

If they disagree with the second-opinion, they may ask for a third opinion. If they request a third-opinion, they must go through the same process they went through for the second opinion.

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Remember that if within an MPN and they do not make an appointment within 60 days of obtaining another MPN list, they will **not** be allowed to have a third opinion with regard to this disputed **diagnosis** or **treatment** of this treating physician.

If they disagree with the third opinion doctor, they may ask for an MPN **Independent Medical Review (IMR)**, if within the MPN. Their employer or MPN contact will give them information on requesting an Independent Medical Review and a form at the time they request a third-opinion.

If either the second or third-opinion doctor or Independent Medical Reviewer agrees with your need for a treatment or test, they will be allowed to receive that medical service from a provider within the MPN or if the MPN does not contain a physician who can provide the recommended treatment, they may choose a physician outside the MPN within a reasonable geographic area.

If the injured employee is in the ADR Program, they will need to contact their Ombudsperson to discuss options under their ADR Program.

- ✓ The Provider will adhere to Risico's client custom MPN, ADR Medical Provider List and/or PPO protocol when recommending ancillary treatment, diagnostics, medications and durable medical equipment.

TREATMENT AUTHORIZATON REQUESTS

- ✓ Risico Total Managed Care shall make utilization review determinations involving health care services, which requires pre-authorization and provide notice of a determination to the insured's designee and the insured's health care providers per applicable regulatory timeframes and if additional information is necessary to make a determination, a request for this information will be communicated to the requesting physician within five (5) business days of receipt of the original request for authorization. Once the necessary information is received a determination will be made within five (5) business days from receipt of requested information, but no more than fourteen (14) calendar days from receipt of the original request for authorization.
- ✓ Risico shall provide prompt notice of its decision an authorization, delay, deny or modify its decision on an Employee's claim to the Employee, the Employee's Primary Treating Physician and to Provider, and shall advise the Employee, Provider and the Employee's Primary Treating Physician of any subsequent change in the status of the claim. Provider shall refer to all inquiries from Employee's about the compensability of their workers' compensation claims to Risico if within an MPN or to the Ombudsperson if within an ADR.

EMERGENCY CARE

- ✓ An emergency service is any health care service provided to evaluate and/or treat any medical condition such that a prudent layperson possessing an average knowledge of medicine and health, believes that immediate unscheduled medical care is required.
 - Treatment and services for Emergency Health Care Services do not require preauthorization. While preauthorization is not required, Risico may request documentation and may also review through retrospective utilization review to determine if the recommended treatment was medically necessary to cure or relieve the injury or condition and will also determine whether the injury or condition is compensable under workers' compensation. If found non-compensable, Risico may modify or deny services.

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TERMS

- ✓ Compliance with Risico's Continuity of Care Policy upon Termination. Primary Treating Physicians(s)/Specialist Physician(s)/Medical Provider(s) that have been terminated from the Risico client customized MPN/ADR Medical Provider List shall comply with the Risico Continuity of Care Policy per the California Code of Regulations and the Labor Code. For a copy of Risico's Continuity of Care Policy, please go to www.risico.com – Get Started – Medical Provider Network Lookup – Continuity of Care.
- ✓ Risico Claims Management adjusters will follow the Risico client customized MPN/ADR Continuity of Care Policy as per the California Code of Regulations and Labor Code. Continued treatment and payment rendered will be based on the merits of each individual claim.
- ✓ Provider shall continue Continuity of Care until an injured employee has secured a new Primary Treating and/or Secondary Treating Physician if a transfer of care is warranted.

PHARMACY

- ✓ Risico has partnered with myMatrixx to make filling workers' compensation prescriptions easy. Injured employees are provided temporary prescription cards and will receive their permanent prescription care specific to their injury within three (3) to five (5) business days. Please provide a prescription for the medication and direct the injured employee to myMatrixx. If injured employee's need assistance with locating a pharmacy near them, they can call myMatrixx at (877) 804-4900.

BILL REVIEW

- ✓ All bills will be reimbursed per Regulation 9789.12.13. The National Correct Coding Initiative Edits ("NCCI") adopted by the CMS shall apply to payments for medical services under the Physician Fee Schedule. Except where payment ground rules differ from the Medicare ground rules, claims administrators shall apply the NCCI physician coding edits and medically unlikely edits to bills to determine appropriate payment.
- ✓ If an employee has filed a claim form pursuant to Section 5401, a provider of medical services shall not, with actual knowledge that a claim is pending, collect money directly from the employee for services to cure or relieve the effects of the injury for which the claim form was filed, unless the medical provider has received written notice that liability for the injury has been rejected by the employer and the medical provider has provided a copy of this notice to the employee. Any medical provider who violates subdivision (LC 3751(b)) shall be liable for three times the amount unlawfully collected, plus reasonable attorney's fees and costs.
- ✓ Risico will reimburse all billings of the Provider within 45 days of receipt of invoice by Risico or 60 days for all public entities. All payments of contested billings for denied claims are subject to nonpayment at the discretion of the Risico clients unless pre-authorization has been obtained. Services duly and properly authorized shall not be denied for payment even if the claim is disputed. Until the date a claim is accepted or rejected, Risico's client liability for all medical treatment, including emergency services

pertaining to the claim will be limited to \$10,000. The scope of the bill review may include whether the bill would reflect generally accepted billing practices and whether the frequency and intensity of services lies within the rules and regulations of the California Labor Code or the California Administrative Regulations applicable to workers compensation injuries. Risico may deny payments for services that have not been approved by its Bill Review Program; however, there shall be no retroactive denial of

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services on the basis of medical necessity when such services were previously reviewed by Risico's Utilization Review Program.

- ✓ In order to expedite payment, please verify all submitted bills contain the following information:
 - Bill must be legible
 - Billed charges for each service
 - CPT/Procedure or NDC
 - Date of birth of injured employee
 - Date of injury of injured employee
 - Dates of service
 - Diagnosis code
 - If known, claim number
 - Number of services or drug quantity (units), if applicable
 - Only new charges – services where payment has already been made should not be on the bill. A separate reconsideration request should be sent if prior payment is being disputed.
 - Patient name
 - Provider tax identification
 - Remit address
 - Report must be submitted with the bill
 - Social Security Number

- ✓ All bills should be submitted to Risico Claims Management/Risico Total Managed Care via mail at:

Risico Claims Management/Risico Total Managed Care
P.O. Box 9839
Fresno CA 93794-9839

- ✓ The review by Risico shall be based on the date that the billing was received in the Risico office for review and **not** by the date of service. The provider will only provide Medically Necessary Services.

TAX IDENTIFICATION NUMBER

- ✓ Provider hereby acknowledges that any provider who bills under the taxpayer identification number of the participating group for the provision of covered services shall be bound by the payment provisions (State OMFS) and reimbursement amounts identified in Agreement.

RECOVERY OF OVERPAYMENT TO THE PROVIDER

- ✓ If, upon audit of the Provider's billing(s), Risico determines that Risico has made an overpayment to the Provider, Risico shall request, on behalf of its client, reimbursement of the amount of excess payment. Risico shall make all overpayment reimbursement requests to the Provider in writing, referencing the injured employee's name, account information (if available), Risico client's name and address, the claim number and copies of the bills in question.

- ✓ The provider shall in turn reimburse Risico the overpaid amount within 30 days of receipt of the reimbursement request, subject to the provisions below. The Provider's reimbursement payment must be made payable to the client with Risico's address and reference the patient's name as well as the Risico client claim number. If however, the Provider rejects the request for reimbursement of an overpayment, the Provider must provide a letter of objection. The letter of objection shall be sent to:

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Risico Total Managed Care, Inc.
P.O. Box 9839
Fresno CA 93794-9839

- ✓ The letter of objection must be received by Risico no later than 30 days after the Provider's receipt of the request for reimbursement. The Provider's objection must include a detailed outline of the basis for objection to the request for overpayment reimbursement.
- ✓ Any request for a refund by Risico shall not be made after six (6) months from the last date medical services were provided.

DISPUTE RESOLUTION

- ✓ In the event of a claim, dispute or other matter between Provider and Risico arising out of, relating to, or in any way connected with this Agreement (collectively, "Disputes", or each, individually, a "Dispute), including the performance of or failure to perform any term, covenant, or condition of the MPN and/or ADR, either Provider or Risico shall submit a notice regarding the nature of the Dispute to the other party. Thereafter, Provider and Risico shall meet and confer in good faith to resolve the Dispute or Disputes within 30 days of notice.
- ✓ If a Dispute is not resolved by the parties within 30 days after notice, at the election of either party, the Dispute shall be submitted to binding arbitration in accord with the provision governing arbitration set forth in the California Code of Civil Procedure, Section 1280, et seq., except that notice shall be given as set forth. The parties will cooperate with one another regarding the scheduling and administration of the arbitration. The chosen Arbitrator may permit discovery reasonably necessary for the fair presentation of the parties' case and not otherwise. The Arbitrator may not award punitive or multiple damages. The arbitration award may be entered as a judgement in accord with applicable law in any court having jurisdiction. Venue shall be Fresno County, California. An arbitration under this Section shall be consolidated with any other arbitration that includes claims by or against Provider or Risico based on the same incident, transaction or related circumstances.
- ✓ It is further agreed that the parties will bear one half of the Arbitrator's costs and fees for Arbitration. However, the prevailing party as determined by the Arbitrator shall be entitled to their attorney's fees and recoverable costs in such a proceeding. The determination of who is the prevailing party shall be a decision by the Arbitrator at the time a cost bill is submitted.
- ✓ The parties herein specifically agree that it is their mutual intent to waive the entitlement to enforce any provision of Agreement in a court of law and likewise waive any entitlement to a trial by jury. Likewise the parties herein agree that the selected arbitrator shall not have the power nor authority to award punitive or multiple damages. The parties agree that the ability to acquire a prompt and economic arbitration decision outweighs the need for enhanced damages and that arbitration of any and all disputes under the terms of Agreement is in the collective best interest of the parties. The only exception to this agreement to arbitrate any and all disputes is set forth as follows:
 - In addition to any other rights and remedies the parties may have under Agreement, each party shall have the right to equitable and injunctive relief in a court of law to prevent the unauthorized use or disclosure of confidential information only.

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NOTICE

- ✓ All notices shall be deemed sent when received by the other party. Unless expressly provided otherwise, all notices to be given, or which may be given, by any party to the other, shall be in writing and shall be deemed to have been fully given when received, if personally delivered or sent by the United States mail, or delivered by overnight delivery service with written proof of delivery.
- ✓ Any party that changes its address shall promptly notify the other party of its new address in accordance with this Section and the following:
 - The provider represents that it has neither changed the physical address where medical services are provided nor changed the Federal Tax Identification Number (TIN) under which it provides medical services.
 - The Provider and/or Affiliate shall immediately notify Risico of any of the following:
 - Any additional Provider and/or Affiliate locations and any change in street address of the office, clinic, or institution where Provider and/or Affiliate provides medical services.
 - Any change in the Federal TIN of any Provider and/or Affiliate providing medical services within the Risico client customized MPN and/or ADR Medical Provider List, resulting in the necessity of a new Form W-9.
 - Any change in Physician and/or affiliate Provider Roster, at a treating location.
 - Any change in licensure status of any of the Provider(s) and/or Affiliate(s) providing services to the MPN, ADR and/or PPO.
 - Any change in business status related to the requirements governed by local, state and federal business laws or regulatory requirements.
- ✓ Notification must be completed in writing within 10 days of any changes listed above, at which time a decision will be made by the MPN, ADR and/or PPO as to whether the change will require an Amendment to the existing Agreement, or require a new Application and Agreement to participate in the MPN, ADR
- ✓ and/or PPO. Any failure to notify Risico within 30 days of such change is considered a material breach and will be a basis for immediate termination. Risico has the right to approve or disapprove of any such change in the MPN, ADR (Joint Committee) and/or PPO Providers.

ANCILLARY

- ✓ Medical Ancillary Services and Durable Medical Equipment (DME) providers, shall perform and provide as follows:
 - Ancillary and DME providers at all times, shall be in compliance with Credentialing Criteria; and
 - Perform the Covered Services pursuant to the requirements of state licensure, applicable state and federal certification, applicable accreditation requirements and standards; and
 - Comply with the rules, regulation, policies, procedures as enacted by Risico, comply with Utilization Management Program, participate in and observe the protocols of the Utilization Program, submit to patient performance reviews/reports, management reports, metric reports, comply with all Risico treatment plan Medical Director inquiries, and bill review requests for

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service detail and invoicing in conjunction with services provided to the covered injured workers therewith.