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## **Assignment and Postponement of Hearings and the Authority of Claims Personnel**

### **Sec. 31-279-1. Claims administration**

(a) As a condition of procuring a certificate of self-insurance or a license to write workers' compensation insurance, each self-insurer or carrier shall maintain a staff of claims adjusters or attorneys of sufficient size to attend hearings in the various districts at times convenient to the injured employee and the compensation commissioner.

(b) The employer, and his service company where applicable, shall complete a certification of servicing for self-insurers form and file it with the chairman or his designee.

(c) The chairman or his designee shall be notified immediately of any change of third party administrator.

(d) The claims administrator shall notify the chairman or his designee in writing within fourteen (14) days of a self-insured employer's failure to provide adequate funding for timely payment of benefits.

(Effective November 30, 1971; amended October 1, 1996)

### **Sec. 31-279-2. Attendance at hearings**

Punctual appearance by an authorized representative at every conference or hearing assigned by the commissioner is required, unless such attendance is excused by the commissioner prior to the conference or hearing.

(Effective November 30, 1971)

### **Sec. 31-279-3. Request for continuance**

Except in cases of unforeseeable emergency, requests for continuances shall be made in time to provide adequate notice to all parties, and should normally not be made ex parte, but only after communication with other parties to the claim.

(Effective November 30, 1971)

### **Sec. 31-279-4. Basis for decision**

Unless prior approval for cause is secured from the commissioner, a claim assigned for a formal hearing shall be decided on the basis of the evidence adduced by the parties at the time and place designated. No party can assume the granting of a continuance to produce witnesses at a later date, or for any other reason not regularly recognized in a judicial proceeding.

(Effective November 30, 1971)

### **Sec. 31-279-5. Voluntary agreements and stipulations**

Representatives of carriers and self-insurers who appear at informal and formal hearings shall be authorized by their principals to enter into voluntary agreements and stipulations, at least up to a minimum amount, and an agent with full authority for each principal shall be reasonably accessible by telephone at the time of hearing.

(Effective November 30, 1971)

### **Sec. 31-279-6. Assignment of hearings**

An assignment should normally be requested of a compensation commissioner only when prior consultations between the parties have failed to achieve an agreement which can be reduced to writing. It shall therefore be considered an impropriety for a hearing to be requested by an employer or carrier with no prior discussions between the claimant and the respondent.

(Effective November 30, 1971)

## **List of Approved Physicians and Fees for Professional Services**

### **Sec. 31-279-7.**

Repealed, November 23, 1993.

### **Sec. 31-279-8. Fees for professional services**

Until such time as the board of compensation commissioners shall establish fees for professional services as authorized by section 31-279, the pecuniary liability of the employer for medical and surgical services rendered injured employees shall continue to be measured by the standard set out in section 31-294; namely a limitation to such charges as prevail in the same community or similar communities for similar treatment of injured persons of a like standard of living when such treatment is paid for by the injured persons.

(Effective July 9, 1973)

### **Sec. 31-279-9. Obligations of attending physician**

Persons who supply professional services to injured employees entitled to medical care by virtue of chapter 568 of the general statutes shall be presumed to agree to the following conditions:

(a) The employer or its insurance carrier will receive an early original report of injury, and such regular subsequent progress reports from the attending physician as may be reasonably required in each case.

(b) No fee will be charged by the attending physician for the completion of any of the forms approved by the board of compensation commissioners or for routine progress reports submitted to the employer or carrier. Where detailed reports are requested or indicated, requiring a significant expenditure of time by the attending physician, a reasonable additional charge for such time will be appropriate.

(c) It shall be the duty of the attending physician, without specific request, to keep the employer or insurance carrier advised of any significant development in the course of his treatment, such as the attainment of maximum medical improvement, a hospital, admission, a surgical procedure, a failure to accept indicated treatment or to keep scheduled appointments, or an ability to return to gainful employment.

(d) Upon reasonable notice, an attending physician will make himself available as a witness in hearings before a compensation commissioner, for which appearance he will be entitled to be paid a reasonable fee by the party requesting his attendance, subject to the pertinent provisions of law.

(e) All charges for medical, surgical, hospital and nursing services, except those for expert testimony, shall be solely the responsibility of the employer or carrier, and no claim will be made against the injured employee for all or part of a fee.

(f) It will be considered professionally reprehensible for a physician to refuse to send out his patient's medical report to a party properly entitled because his medical bill for services rendered has not been paid up to that time.

(g) Violation of these regulations shall constitute sufficient cause for a removal from the approved list of physicians maintained by the board of compensation commissioners.

(Effective July 9, 1973)

### **Sec. 31-279-10. 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 a Workers' Compensation Commissioner. 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 a Workers' Compensation Commissioner 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.

(Effective March 25, 1993; amended December 2, 1997)