

WECARE[®] MANAGED CARE PROGRAM

Welcome to the *FHM Insurance Company WECARE Managed Care Program*

Following are the commitments required of the **EMPLOYER**:

- ◆ Select Medical Care Coordinator(s) – the physician(s) and/or clinic(s)/hospital(s) from the Rockport Network (approved county list). More than one Medical Care Coordinator may be selected.
- ◆ Educate each current and new employee immediately on the requirements of the **WECARE** Managed Care Program, as well as their rights and responsibilities.
- ◆ Obtain each employee's signature on the **WECARE** Employee Agreement (Employee Safe Working Practices/Managed Care), to be placed in the personnel file of both current and new employees. Each employee should also receive a copy of this Employee Agreement.
- ◆ The enclosed Grievance Procedure and Formal Grievance Form must be distributed to all employees. Additionally, this procedure form should be posted near Medical Care Coordinator(s) information.
- ◆ Once you have selected the Medical Care Coordinator, post his/her name, address and telephone number in a prominent place visible to all employees.
- ◆ Read the enclosed information on the **Matrix** Pharmacy Program. If injured employee will require prescription drugs, issue him/her a **Matrix** Pharmacy Form and “Dear Injured Worker” letter at time of injury or treatment.
- ◆ Direct any employee who requests treatment for a work-related injury to the Medical Care Coordinator. The Introductory Letter to Physician must accompany injured employee on the initial visit. **NOTE: (1)** For emergency (life threatening) medical treatment, contact nearest medical facility. **(2)** If your operation is a drug-free workplace, modify the Introductory Letter to the physician to request a drug test. **(3)** Any employee who does not receive treatment from the Medical Care Coordinator may have his/her Workers' Compensation benefits denied.
- ◆ Report injury via telephone to FHM within 24 hours of knowledge of injury – 888-346-3461, **Ext. 353**.
- ◆ Provide return-to-work employment for injured employee within the scope of the Medical Care Coordinator's requirements.

The following **WECARE** management forms are enclosed for your use. Please reproduce as needed:

- Employee Agreement – must be signed by each employee ★
- Introductory Letter to Physician - must accompany injured worker on initial visit ★
- Grievance Procedure★ and Formal Grievance Form

★ *These forms are also available in Spanish, upon request.*

- Network Directory — additional counties available upon request.

If you need to locate a Network provider or inquire about a Medical Care Coordinator in your area, please contact your Nurse Case-Manager or adjuster at FHM Insurance Company at 888-346-3461 ext.323.

Or visit FHM's website at www.fhmic.com to access the Online Medical Provider Directory.

- Provider Nomination Form – Note: Use this form to add a Medical Care Coordinator to **Rockport** Network Directory
- Questions & Answers about **WECARE**
- **Matrix** Pharmacy Program
- “Dear Injured Worker” letter regarding the **Matrix** Pharmacy Program
- **Matrix** Pharmacy Form (2/page) -- for initial prescriptions only
- Questions & Answers about the **Matrix Pharmacy Program**

Additional forms are available by calling Extension 401/424.

Working together on the **FHM Insurance Company's WECARE** program will enable us to control medical and indemnity costs by returning the injured employee to productive work as soon as possible.

EMPLOYEE AGREEMENT EMPLOYEE SAFE WORKING PRACTICES/MANAGED CARE

As a condition of employment, I _____ do hereby agree to comply
(Please print full name)
with the following Employee Safe Working Practices and Managed Care Program.

1. I agree to follow established departmental safety procedures.
2. I agree to report any work-related accident or injury to my supervisor as soon as it occurs, but no later than the end of my duty shift.
3. If I need treatment for a work-related injury, I understand that my employer has enrolled in a Managed Care Program for Workers' Compensation with **FHM Insurance Company WE CARE program and AmeriSys/Rockport Network** and that the following procedures must be followed for all work-related injuries and illnesses. It is important to note that Florida Statute 440.134(17) states "**...Treatment received outside the Workers' Compensation managed care arrangement is not compensable unless authorized by the carrier prior to the treatment date.**"
 - ✓ Report promptly any work-related injury to supervisor.
 - ✓ Hand carry the Introductory Letter to Physician to the Medical Care Coordinator on the initial visit.
 - ✓ Follow the Medical Care Coordinator's instructions for any additional specialist treatment, if needed.
 - ✓ **Ensure all medical treatment is handled only through the Medical Care Coordinator.**
 - ✓ Direct all questions about level of care to the Medical Care Coordinator, who is the focal point for medical treatment.
 - ✓ Follow established Grievance Procedures to resolve any dissatisfaction with medical treatment.

I understand that failure on my part to follow the above procedures could result in disciplinary action not to exclude termination and loss of Workers' Compensation benefits.

I also understand that according to Section 440.09(5) of the Florida Workers' Compensation Law, my compensation benefits could be reduced for any injury that occurs because of failure to follow established safety procedures.

Employee Signature

Date

Witness Signature

Original to Personnel File / Copy to Employee

**INTRODUCTORY LETTER TO PHYSICIAN
AmeriSys/Rockport**

Date: _____
 Employer Name: _____
 Employer Telephone Number: _____

Dear Dr. _____:

_____ is scheduled for an initial visit as an employee of _____ which is a participant in the **FHM Insurance Company/ Rockport Network**. This letter does not confirm that the injury or condition is covered by Workers' Compensation insurance. That determination will be made as soon as an investigation is completed by our claims administrator, United Self Insured Services.

DRUG TESTING IS REQUIRED: Urinalysis
 Breathalyzer (blood test if necessary)

We are working closely with Rockport and the involved medical providers to ensure that our employees receive access to timely and medically necessary treatment for their industrial injuries. In the best interest of our employees, we will have modified work available, which would allow the employee to return to work at the earliest possible date. Please keep this in mind as you treat this employee.

**PLEASE CONTACT UTILIZATION MANAGEMENT
 AT 407-351-1212/888-346-3461 Ext 323
 WHEN ONE OF THE FOLLOWING OCCURS:**

1. New Injury with Disability > 7 Days & No Release to Return to Work
2. Hospitalization
3. Anticipated Surgery
4. Physical Therapy or Chiropractic Treatment Recommended
5. Referral to Provider
6. Assistance Required to Return Injured Employee to Work
7. Repeat Major Diagnostic Studies

All claims for treatment must be submitted to the address below on an HCFA 1500, UB 92 or the appropriate form required by the State. Please submit all medical reports within the time frame required by the applicable State law.

**FHM Insurance Company
 P.O. Box 616648, Orlando, FL 32861-6648
 407-351-1212/888-346-3461 Ext 350**

Should you have any questions regarding your participation in the Rockport Network, please refer to the Rockport Network Workers' Compensation Provider Manual or contact your Rockport PPO Department Representative at Rockport Healthcare Group, 50 Briar Hollow Lane, Suite 515 West, Houston, TX 77027, 713-621-9424.

Sincerely,

Print Name

Signature

FHM Insurance Company
WECARE[®]
WORKERS' COMPENSATION

GRIEVANCE PROCEDURE

IF YOU ARE INJURED ON THE JOB

Your employer and Workers' Compensation carrier are concerned that you receive appropriate medical treatment.

Your employer has a list of health care providers and can assist you in selecting a provider from within the Rockport Network. If you need to be referred to another provider or need emergency care, you may choose from the list of providers participating in the Network.

If you are dissatisfied or have questions concerning the medical care and treatment provided by a **WECARE** provider, you may, within one year from the date of treatment or care in question, file a complaint by contacting the Grievance Coordinator or your Nurse Case-Manager at 888-346-3461, ext. 323.

The Grievance Coordinator and/or Nurse Case-Manager will coordinate a resolution to the complaint and contact a Physician Advisor if necessary. The Physician Advisor may require medical examinations and/or other information from you and the Network provider depending on the nature of the dispute. If the Physician Advisor is unable to resolve the dispute to your satisfaction within ten (10) days, the matter will automatically be referred to the Medical Director.

The Medical Director will issue a decision within thirty (30) days unless further information is required, in which case an additional thirty (30) days will be allowed. If an agreement is not reached and you are not satisfied with the decision of the Medical Director, you may file a request for grievance reconsideration with the Division of Workers' Compensation.

If you have any questions concerning the Rockport Network, call 888-346-3461, ext. 323 or write:

Rockport Healthcare Group
50 Briar Hollow Lane
Suite 515 West
Houston, TX 77027

Florida Workers' Compensation Managed Care Arrangement
FORMAL GRIEVANCE FORM

An Injured Worker or Health Care Provider shall use this form to request a formal review about dissatisfaction with medical care issues provided by or on behalf of a Workers' Compensation Managed Care Arrangement.

This Grievance is Filed by: ___ Provider ___ Injured Worker or a Designated Representative: ___ Family Member ___ Attorney ___ Other
Date of Injury _____

INJURED WORKER'S/PROVIDER'S NAME: _____
Social Security Number _____
Address: _____
Home Telephone: _____ Work/Alternate Phone: _____
Contact if other than injured worker or provider _____ Telephone # _____

PRIMARY CARE/TREATING PHYSICIAN: _____
Address: _____
Office Telephone: _____

If the space provided below is inadequate for you to fully explain your concern or the action you desire, continue your statement on a sheet of plain paper. Please be sure your name and social security number appear on each page of any attachment.

Why is this grievance being filed? (Nature of the problem): _____

Has a grievance been previously filed? ___ YES ___ NO IF YES, Date sent? _____
What Action Would You Like to See Taken? _____

Have you received any information regarding your rights and responsibilities under WC Managed Care? Yes ___ No ___

INTENT: The grievance procedure is intended to be self-executing and easy to use. An injured worker may call the grievance coordinator directly without completing this form. The grievance coordinator may complete the form for the injured worker. A review regarding the requested medical care will begin immediately, and a decision made within 44 days of receipt unless additional information is required from outside the service area. The review period may be extended by mutual agreement between the injured worker and the grievance coordinator, with notice provided to all other participating parties.

The injured worker's participation in the grievance process is important to the resolution of medical issues. Individuals reviewing the grievances may need to speak directly with and receive input from the injured worker. If the injured worker is unable to participate actively in the grievance process, a patient advocate may participate on behalf of the injured worker.

If the injured worker, employer, or carrier is dissatisfied with the final decision of the grievance committee, the dissatisfied party has the right to file a Petition for Benefits with the Florida Division of Workers' Compensation.

Any person who, knowingly and with intent to injure, defraud, or deceive any employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Form Completed by: _____
Injured Worker/Provider/Other

Date Form Completed/Signed

Signature of Grievance Coordinator

Date Grievance Coordinator Signed

MAIL TO: Grievance Coordinator
AmeriSys
PO Box 616648
Orlando, FL 32861-6648
407-351-1212, ext. 417

**WORKERS' COMPENSATION WECARE[®] NETWORK
PROVIDER NOMINATION FORM**

*All information in the box below must be completed prior to forwarding to Rockport.
The form will be returned if incomplete.*

Employer Name:	_____
Address:	_____
City, State, Zip:	_____
Telephone #:	_____
Requestor Name:	_____
Requestor Telephone #:	_____
Provider Name:	_____
Group Name:	_____
Provider Specialty:	_____
Address:	_____
City, State, Zip:	_____
Telephone #:	_____
Client's \$ volume with provider:	_____
Period represented: From:	_____ To: _____
Source of Data (1099):	_____
Other:	_____

Tax ID # (if available): _____

Contact Person (if available): _____

Hospital Affiliation (if known): _____

Reason for Nomination: _____

Comments: _____

Signature: _____ Date: _____

Please forward to:

**AmeriSys
Attn: Linda Simpson
PO Box 616648
Orlando, FL 32861-6648
407-351-1212, ext. 323 / Fax #: 407-363-9116**

Internal Use Only:
Date Received: _____
Recruitment Letter Sent: _____
Date of Last Contact: _____
Current Status: _____

Managed Care Representative: _____

FREQUENTLY ASKED QUESTIONS BY EMPLOYERS ABOUT *WECARE*

Q: *May I choose more than one Medical Care Coordinator?*

A: YES. This will be particularly useful with multi-location insureds.

Q: *May I get my current provider in the Network?*

A: We encourage you to use the existing Network. If there is a business need to add a provider, you may send in the Provider Nomination Form to FHM.

NOTE: The law specifies that the Medical Care Coordinator (MCC) must be within a 30-minute drive and the specialist within a 60-minute drive of the employer location.

Q: *If a hospital is listed in the Network, does this automatically include the occupational clinics associated with the hospital?*

A: NO. Any questions regarding provider location can be referred to Rockport Network On-Line number (800) 229-4637.

Q: *Will a claim number be assigned when calling in the First Report of Injury?*

A: YES.

Q: *Is it necessary to mail/FAX the First Report of Injury after reporting it via telephone?*

A: NO. FHM will send copies of the First Report of Injury or Illness to the employee, employer and the State.

Q: *Because I am calling in the First Report of Injury, must I still maintain the OSHA log?*

A: YES. This is required by the government.

Q: *How long will it take for the copy of the First Report of Injury to be sent?*

A: Within 24 hours of calling it in.

Q: *Will my Network Medical Care Coordinator know that we have a drug-free workplace program and do the appropriate testing?*

A: NO. You will need to notify the Medical Care Coordinator that this needs to take place. NOTE: It is important for you to establish a relationship with your Medical Care Coordinator so he/she is aware of your individual needs.

Q: *May I send an injured worker directly to a specialist?*

A: NO. You must first send them to the Medical Care Coordinator, who will make the referral to the specialist if necessary.

Q: *Where do I send my injured worker after hours?*

A: If it is a life-threatening emergency, you may utilize the nearest hospital. Otherwise, direct the employee to the nearest Network urgent care center or Network hospital emergency room.