

RULE 51
MANAGED CARE
PURPOSE

- A.** The purpose of Rule 51 through Rule 61 is to establish procedures and requirements for certification of a managed care plan relating to the management and delivery of medical, surgical, and hospital services to injured employees under the Nebraska Workers' Compensation Act, and for contracting between a certified managed care plan and an insurer, risk management pool, or self insured employer.
- B.** No health care provider, network of providers, employer, insurer, risk management pool or any other person may make any representation or state in any name, contract, or literature that an entity constitutes workers' compensation managed care for the provision of services under the Nebraska Workers' Compensation Act unless the entity is a certified managed care plan under these rules.
- C.** No employee may be required to receive services under a managed care plan, including but not limited to a preferred provider organization, point of service plan, health maintenance organization, or similar entity, unless the plan has been certified by the court.

Sections 48-120.02, 48-163, R.R.S. 2010, and 48-120, R.S. Supp., 2014.

Effective date: July 1, 1997.

RULE 52
MANAGED CARE
APPLICATION FOR CERTIFICATION

Words in italics are defined in Rule 49.

- A. Application.** Any person or entity may make written application for certification by the court of a plan to provide management of quality treatment to injured employees for injuries and diseases *compensable* under the Nebraska Workers' Compensation Act. Any such application shall be submitted to the court, together with one identical copy, and shall include the following information.
1. The Application must describe the manner in which the plan will meet the requirements of Rule 51 to Rule 61 and section 48-120.02, including a description of the times, places, and manner of providing *health care services* under the plan, and a statement describing how the plan will ensure an adequate number of each category of *health care providers* listed in Rule 53,C is available to give employees convenient geographic accessibility to all categories of *health care providers* and adequate flexibility to choose the *primary treating physician* pursuant to Rule 53,E,3.
 2. The Application must identify the following (an individual may act in more than one capacity):
 - a. the names of all directors and officers of the *managed care plan*;
 - b. the title and name of the person to be the day-to-day administrator of the *managed care plan*;
 - c. the title and name of the person to be the administrator of the financial affairs of the *managed care plan*;
 - d. the name and medical specialty, if any, of the medical director; and
 - e. the name, address, and telephone number of a communication liaison for the court, insurer, risk management pool, employer, and the employee.
 3. The Application must provide a copy of any standard contract used with *health care providers* who will deliver services under the *managed care plan*, and a description of any other relationships with *health care providers* who may deliver services to a covered employee, together with a copy of any related contract. The *managed care plan* must provide a list of names, clinics, addresses, telephone numbers, types of license, certification or registration, and specialties for the *health care providers* subject

to the contracts. The *managed care plan* must also submit a statement that all licensing, certification or registration requirements for the *health care providers* are current and in good standing in Nebraska or the state in which the *health care provider* is practicing.

4. The Application must identify any entity, other than *health care providers*, with whom the *managed care plan* has a joint venture or other agreement to perform any of the functions of the *managed care plan*, together with a description of the specific functions to be performed by each such entity. Copies of the related contracts must also be provided.
5. The Application must disclose to the court the existence of any of the following factors and any equivalent interest the *managed care plan* has in an insurer, risk management pool or employer. The court may consider these factors and any other relevant information in determining whether a *managed care plan* shall be certified. If an insurer, risk management pool, or employer, or any member of the staff of such entity:
 - a. directly participates in the formation or certification of the plan; or
 - b. occupies a position as a director, or other governing member, officer, agent, or employee of the plan; or
 - c. has any ownership interest or similar financial or investment interest in the *managed care plan*; or
 - d. enters into any contract with the plan that limits the ability of the plan to accept business from any other source; or
 - e. has any relationship not listed above with a *managed care plan*, other than a contract for the provision of medical, surgical, and hospital services under the Nebraska Workers' Compensation Act.

Rule 52,A,5 is not intended to prohibit an insurer, risk management pool, or employer, from forming, owning, or operating a *managed care plan*, so long as the plan includes adequate safeguards to insure fairness and equity in the operation of the plan and in the provision of medical, surgical, or hospital services under the plan.

6. The Application must include satisfactory evidence of ability to meet the financial requirements necessary to ensure delivery of service in accordance with the plan.
7. The Application must include a copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, as well as the bylaws or similar document, if any.

8. The Application must identify one place of business in this state where the plan is administered and membership records and other records are kept, or if the plan is located outside the state of Nebraska, the Application must identify one such place of business in such other state and must also include a statement that the plan agrees and stipulates to the jurisdiction of Nebraska courts for all purposes.

B. Fees. Each application for original certification or application for certification following revocation must be accompanied by a nonrefundable fee of \$1,500. The fee for the annual report is established in Rule 57.

C. Notification; approval or denial.

1. An application received by the court shall be approved if such application meets all the requirements as set out in Rules 51 through 61. The court may request of the applicant further information or clarification of information submitted pursuant to Rule 52,A,1 through Rule 52,A,8. Failure to respond to a request from the court or failure to meet the requirements shall result in a denial of certification. A letter detailing the reason(s) for denial shall be sent to the applicant within five working days of the decision by the court to deny the application.
2. An applicant denied certification pursuant to Rule 52,C,1 shall be permitted to reapply no earlier than 30 days after receipt of the notice of denial of certification. Such reapplication shall be accompanied by a nonrefundable fee of \$750. In no event shall an entity be allowed to reapply for one year after having been denied certification three consecutive times.

Sections 48-120.02, 48-163, R.R.S. 2010, and 48-120, R.S. Supp., 2014.

Effective date: October 27, 1998.

RULE 53
MANAGED CARE
REQUIREMENTS FOR CERTIFICATION

Words in italics are defined in Rule 49.

- A. In order to become and remain certified under these rules, a *managed care plan* must meet all the requirements of Rule 51 through Rule 61 as well as those listed in section 48-120.02.
- B. The *managed care plan* must ensure provision of quality *health care services* that meet all uniform treatment standards adopted by the plan or which may be prescribed by the court, and all *health care services* that may be required under the Nebraska Workers' Compensation Act in a manner that is timely, effective and convenient for the employee. The employer shall remain liable for any *health care service* required under the Act that the *managed care plan* does not provide.
- C. The *managed care plan* must have contracted for, at a minimum, the following types of *health care services and providers*, unless the *managed care plan* is unable to contract for a particular service or type of provider. If the *managed care plan* is unable to contract for a particular service or provider, then the *managed care plan* shall provide an explanation. The *managed care plan* must provide to an employee at a minimum, when necessary, the following types of *health care services and providers*:
1. medical doctors in at least one of the following specialized fields: family practice, internal medicine, occupational medicine, psychiatry or emergency medicine;
 2. orthopedic surgeons;
 3. specialists in hand and upper extremity surgery;
 4. neurologists;
 5. neurosurgeons;
 6. general surgeons;
 7. chiropractors;
 8. podiatrists;
 9. osteopaths;
 10. dentists;
 11. dermatologists;

12. ophthalmologists;
13. optometrists;
14. physical therapists;
15. occupational therapists;
16. psychologists;
17. psychiatrists;
18. diagnostic pathology and laboratory services;
19. radiology services;
20. hospital services;
21. outpatient surgery; and
22. urgent care services.

D. The *managed care plan* must provide for referral for any services that are not specified above in Rule 53,C that are required under the Nebraska Workers' Compensation Act.

E. The *managed care plan* must include procedures to ensure that employees will receive *health care services* in accordance with the following:

1. Employees must receive initial evaluation by a *participating* licensed *physician* in one of the disciplines listed below in Rule 53,E,3 within 24 hours of the employee's request to the *managed care plan* for treatment following an injury. The *managed care plan* may select the *physician* to do the evaluation.
2. In cases where the employee has received treatment for the work injury by a *physician* outside the *managed care plan* under Rule 56,A,1 or Rule 56,A,6 the employee must receive initial evaluation or treatment by a *participating* licensed *physician* within five working days of the employee's request for a change of doctor, or referral to the *managed care plan*. The *managed care plan* may select the *physician* to do the evaluation.
3. Following the initial evaluation and upon request, the employee must be allowed to choose to receive ongoing treatment from any one *participating physician* in one of the disciplines listed below as the *primary treating physician*, if the *physician* is available within the mileage limitations established in Rule 53,E,7, if the treatment is required under the Nebraska Workers' Compensation Act, if the treatment is within the provider's scope of practice, and if the treatment is appropriate under the standards of treatment adopted by the *managed care plan*:

- a. medical doctors;
- b. chiropractors;
- c. podiatrists;
- d. osteopaths; or
- e. dentists.

An evaluating *physician* may also be offered as a *primary treating physician*.

The *primary treating physician* may arrange for any consultation, referral, or extraordinary or other *specialized medical services* as the nature of the injury shall require, as permitted under the *managed care plan*.

4. Employees must receive any required treatment, diagnostic tests, or *specialized medical services* in a manner that is timely, effective, and convenient for the employee.
 5. Employees must be allowed to change *primary treating physicians* within the *managed care plan* at least once by making application for such change to the plan without proceeding through the *managed care plan's* dispute resolution process. A change of *physician* from the evaluating *physician* to a *primary treating physician* for ongoing treatment is not considered a change of *physician*, unless the employee has received treatment from the evaluating *physician* more than once for the injury.
 6. Employees must be able to receive information at no cost on a 24-hour basis regarding the availability of *health care services* under the *managed care plan*. The information may be provided through recorded telephone messages after normal working hours. The message must include information on how the employee can obtain emergency services or other urgently needed care, and how the employee can receive an evaluation.
 7. Employees must have access to the evaluating and *primary treating physician* within 30 miles of either the employee's place of employment or residence if either the residence or place of employment is within a city with a population of 5,000 or more. If both the employee's residence and place of employment are outside a city with a population of 5,000 or more, the allowable distance is 60 miles. If the *primary treating physician* is not available within the stated mileage restrictions then a *nonparticipating physician* may be selected pursuant to Rule 56,A,5.
- F. The *managed care plan* must designate the procedures for approval of services from a *physician* outside the *managed care plan* as permitted in Rule 56,A,1

through Rule 56,A,6, and how such *physician* will be informed of the rules, terms, and conditions of the *managed care plan*, and the procedures for referring an employee to the *managed care plan* for any other treatment that the employee may require.

- G. The *managed care plan* must include a procedure for peer review and utilization review as specified in Rule 59.
- H. The *managed care plan* must include a procedure for internal dispute resolution as specified in Rule 58.
- I. The *managed care plan* must describe how employers, insurers, and risk management pools will be provided with information that will inform employees of all choices of *physician* under the plan and how employees can gain access to those *physicians*. The plan must submit a proposed notice to employees, which may be customized according to the needs of the employer, but which must include the information required by Rule 55.
- J. The *managed care plan* must describe how aggressive medical case management will be provided as specified in Rule 60, and how a program for early return to work and cooperative efforts to promote workplace health and safety consultative services will be provided.
- K. The *managed care plan* must describe a procedure or program through which *health care providers* may obtain information on the following topics:
 1. treatment parameters adopted by the plan;
 2. maximum medical improvement;
 3. permanent partial impairment rating;
 4. return to work and disability management;
 5. *health care provider* obligations in the workers' compensation system; and
 6. other topics the *managed care plan* deems necessary to obtain cost effective, quality medical treatment and appropriate return to work for an injured employee.

The medical director or designee must be available as a consultant on the topics listed above in Rule 53,K,1 through Rule 53,K,6 to any *health care provider* delivering services under the *managed care plan*.

- L. The *managed care plan* must describe the treatment standards it has adopted or developed, if any, for *health care services* that are to be used in the treatment of workers' compensation injuries. All participating *health care providers* and those nonparticipating providers subject to the rules, terms and conditions of the *managed care plan* shall be governed by such treatment standards. This

paragraph does not, however, require ongoing treatment in individual cases if the treatment is not medically necessary, even though the maximum amount of treatment permitted under any standard has not been given.

- M.** The *managed care plan* may contract for payment of medical, surgical, and hospital services under the plan at fees different from those established by the Diagnostic Related Group inpatient hospital fee schedule established in section 48-120.04 or a fee schedule adopted by the court pursuant to Rule 26.
- N.** The *managed care plan* must maintain a standardized claimant medical record-keeping system designed to facilitate entry of information into computerized databases.
- O.** The *managed care plan* must provide a timely and accurate method of reporting to the court necessary and useable information regarding medical, surgical, and hospital service cost and utilization to enable the court to determine the effectiveness of the plan.
- P.** The *managed care plan* must maintain and provide to the court on request any other information or data as the court considers necessary.

Sections 48-120.02, 48-163, R.R.S. 2010, and 48-120, R.S. Supp., 2014.

Effective date: December 18, 2008.

RULE 54

MANAGED CARE COVERAGE

A. Contracts.

1. In order to provide management of treatment for injuries and diseases compensable under the Nebraska Workers' Compensation Act a managed care plan must contract with:
 - a. an insurer licensed by the Nebraska Department of Insurance to write workers' compensation insurance in this state that has issued a current workers' compensation insurance policy or policies; or
 - b. a risk management pool formed pursuant to the Intergovernmental Risk Management Act that provides group self insurance to member employers; or
 - c. an individual employer approved for self insurance by the court.
2. All contracts pursuant to Rule 54,A,1 shall specify the billing and payment procedures that will be utilized, and how the aggressive case management, early return to work, and cooperative efforts to promote workplace health and safety consultative services will be provided.
3. All contracts pursuant to Rule 54,A,1 shall specify that any contractual obligations of an insurer, risk management pool, or self insured employer to allow a managed care plan to provide medical, surgical, or hospital services for employees pursuant to the Nebraska Workers' Compensation Act shall be null and void upon revocation of the certification of the managed care plan.
4. Once compensability has been accepted or determined, the employer may require that employees subject to the contract shall receive medical, surgical, and hospital services in the manner prescribed in the contract.
5. The employer shall remain liable for any health care services required under the Nebraska Workers' Compensation Act that the managed care plan does not provide.

B. Multiple Plans. An insurer, risk management pool, or self insured employer may contract with multiple managed care plans to provide coverage for employers. When an insurer, risk management pool, or self insured employer contracts with multiple managed care plans to provide coverage for the same employer, and more than one such plan has participating physicians within the mileage restrictions established pursuant to Rule 53,E,7 whose scope of prac-

tice is appropriate for treatment of the injury in question, the employee shall have the right to select the managed care plan that will manage the employee's care; except that if any such certified managed care plan also provides group health insurance for the employer and the employee is obligated to receive services under the group health insurance plan, then that plan, if the employer so elects, shall also manage the employee's care for workers' compensation purposes.

C. Coverage.

1. If an employee gives notice of injury to an employer under the Nebraska Workers' Compensation Act on or after the effective date of the managed care plan contract with the insurer, risk management pool, or self insured employer, and if compensability has been accepted or determined, then the employee may be required to receive services under the managed care plan; except that an employee may not be required to receive services under the managed care plan until the notice required by Rule 55 has been given to the employee.
2. If the employer received notice of the injury before the effective date of the managed care plan contract, the employee may not be required to receive services under the managed care plan until the employee requests a change of physician. At that time the employee may be required to receive further services under the managed care plan.
3. Prior to acceptance or determination of compensability, or subsequent to the denial of compensability, the employee may not be required to receive services under a managed care plan.
4. If compensability is denied by the insurer, risk management pool, or self insured employer, the employee may leave the managed care plan and the employer shall be liable for medical, surgical, and hospital services previously provided.

D. Termination of Coverage.

1. To ensure continuity of care, the managed care plan contract shall specify the manner in which an employee will receive health care services when a managed care plan contract or a contract with a health care provider terminates.
2. When a contract with a participating primary treating physician terminates, the employee may continue to treat with such physician if the physician remains in good standing in Nebraska or the state in which he or she practices, and if the physician agrees to refer the employee to the managed care plan for any other treatment that the employee may require with respect to the injury in question, and if the physician agrees to comply with

all of the rules, terms, and conditions of the managed care plan with respect to treatment of the injury in question.

3. When managed care plan coverage for an employee is transferred from one managed care plan to another, the employee may continue to treat with the primary treating physician selected under the old plan if such physician agrees to refer the employee to the new managed care plan for any other treatment that the employee may require with respect to the injury in question, and if the physician agrees to comply with all of the rules, terms, and conditions of the new managed care plan with respect to treatment of the injury in question. If the employee requests a change in the primary treating physician, further services will be provided under the new managed care plan.

Sections 48-120.02, R.R.S. 2010, and 48-120, R.S. Supp., 2014.

Effective date: July 1, 1997.

RULE 55
MANAGED CARE
NOTICE TO EMPLOYEE

Words in italics are defined in Rule 49.

An employee is not required to receive services under a *managed care plan* until the insurer, risk management pool, or self insured employer gives the employee notice of the information listed below in this rule. Individual notice of such information must be given at the time the employee becomes subject to the contract (see Rule 53,I). The notice must include the following information:

- A. The employer is covered by the named *managed care plan* to provide all required treatment for work related injuries after a specified date. An employee sustaining an injury prior to the specified date is required to receive services under the plan only if the employee changes *physicians*.
- B. The toll free telephone number of the *managed care plan* where the employee can receive answers to questions about managed care.
- C. The employee may receive treatment from a medical doctor, chiropractor, podiatrist, osteopath, or dentist under the plan, if the treatment is available within the community and the scope of practice of the *physician* is appropriate for the treatment of the injury in question.
- D. How the employee can access care under the *managed care plan*, how the employee can identify eligible *physicians*, and the toll free 24 hour telephone number of the *managed care plan* that informs employees of available services.
- E. The employee may be required to receive services from a *participating physician* under the *managed care plan* except in the following circumstances:
 - 1. if the employee or an *immediate family member* has treated with a *physician* prior to the date of injury who can provide treatment appropriate for the injury in question, if the employee selects such *physician* according to rules established by the court, if such *physician* agrees to refer the employee to the *managed care plan* for any other treatment that the employee may require, and if such *physician* agrees to comply with all of the rules, terms, and conditions of the *managed care plan*; or
 - 2. if the employer fails to notify the employee of the right to select a *family physician* according to the rules established by the court;
 - 3. for *emergency medical treatment*; or
 - 4. in cases of injury requiring dismemberment or injuries involving *major surgical operation*, if the employee selects the *physician* to perform the

operation and such *physician* agrees to refer the employee to the *managed care plan* for any other treatment that the employee may require, and if such *physician* agrees to comply with all of the rules, terms, and conditions of the *managed care plan*; or

5. after *compensability* has been denied by the insurer, risk management pool, or self insured employer; or
6. if there is no *participating primary treating physician* available within the mileage restrictions established in Rule 53,E,7 of the Rules of Procedure of the Nebraska Workers' Compensation Court.

Sections 48-120.02, 48-163, R.R.S. 2010, and 48-120, R.S. Supp., 2014.

Effective date: October 27, 1998.

RULE 56

MANAGED CARE PHYSICIANS WHO ARE NOT PARTICIPATING PHYSICIANS

Words in italics are defined in Rule 49.

A. Authorized Services. For provisions relating to choice of *physician* generally, see Rule 50. A *physician* who is not a *participating physician* under the *managed care plan* may provide services to an employee in any of the circumstances listed below under this rule if the scope of practice of the *nonparticipating physician* is appropriate for treatment of the injury in question.

1. A *nonparticipating physician* may be selected as the *primary treating physician* by the employee if:
 - a. the *physician* is a *family physician*;
 - b. the *physician* agrees to refer the employee to the *managed care plan* for any other treatment that the employee may require;
 - c. the *physician* agrees to comply with all of the rules, terms, and conditions of the *managed care plan*; and
 - d. the employee selects the *physician* as required in Rule 50,A following notice by the employer as required in Rule 50,B.

If the *physician* selected by the employee does not agree to refer the employee to the *managed care plan* for any other treatment that the employee may require or to comply with all of the rules, terms, and conditions of the *managed care plan*, the *physician* may not provide services to the employee and the employee may select another *nonparticipating physician* pursuant to Rule 56,A,1.

2. A *nonparticipating physician* may be selected as the *primary treating physician* by the employee if the employer does not give the employee notice, as described in Rule 50,B,2, of the right to choose a *family physician* as the *primary treating physician*.
3. A *nonparticipating physician* may provide services to an employee for *emergency medical treatment*.
4. A *nonparticipating physician* may deliver services to an employee when the employee is referred to such *physician* by the *managed care plan*.
5. A *nonparticipating primary treating physician* may be selected by the employee to provide services if there is no *participating physician* available within the

mileage restrictions established in Rule 53,E,7, or if there is an insufficient number of *participating physicians* within the mileage restrictions to permit the employee to change *primary treating physicians* as permitted under the plan (see Rule 53,E,5); except that a *nonparticipating physician* may be selected in such circumstances only if no *participating physician* is available closer to either the residence or place of employment of the employee whose scope of practice is appropriate for treatment of the injury in question.

6. A *nonparticipating physician* may be selected by the employee in cases of injury requiring dismemberment or injuries involving *major surgical operation* to perform the operation if:
 - a. the *physician* agrees to refer the employee to the *managed care plan* for any other treatment that the employee may require; and
 - b. the *physician* agrees to comply with all of the rules, terms, and conditions of the *managed care plan*.
7. If *compensability* is denied by the insurer, risk management pool, or self insured employer, the employee may leave the *managed care plan* and the employer shall be liable for medical, surgical, and hospital services previously provided. Under such circumstances a *nonparticipating physician* may be selected by the employee to provide services.

B. Change of *Physician*. If the employee requests a change of *nonparticipating primary treating physician*, further services shall be provided in accordance with Rules 53,E.

C. Disputes. Any dispute relating to the selection of a *nonparticipating physician* pursuant to Rule 56,A,1 through 56,A,6, as well as any dispute relating to the obligation of any *nonparticipating physician* to make referrals into the *managed care plan* or to comply with the other rules, terms, and conditions of the *managed care plan* shall be resolved according to the dispute resolution procedures of the *managed care plan*. Any *nonparticipating physician* who has an obligation to make referrals into the *managed care plan* or to comply with the other rules, terms, and conditions of the *managed care plan* and who fails to refer or comply, is subject to denial of payment for the related services.

Sections 48-120.02, R.R.S. 2010, and 48-120, R.S. Supp., 2014.

Effective date: October 27, 1998.

RULE 57

MANAGED CARE REPORTING REQUIREMENTS

- A. Contracts.** A managed care plan shall provide the court with copies of the following contracts:
1. Contracts between the managed care plan and any insurer, risk management pool, or self-insured employer, signed by the parties, within 30 days of execution of such contracts. Such contracts must include a listing of all employers covered by each contract, including the employer's name, address, telephone number, unemployment insurance identification number, and estimated number of employees and location of the employees covered by the managed care plan contract.
 2. Contracts between the managed care plan and any entity other than health care providers that perform any of the functions of the managed care plan, which have not previously been provided with the application for certification. These must be signed by the parties and submitted within 30 days of execution of such contracts.
 3. New standard contracts between the managed care plan and health care providers who will deliver services under the plan, if such contracts have not previously been provided with the application for certification. These must be submitted within 30 days of adoption. Such new contracts must meet the requirements set out in Rule 52,A,3.
- B. Amendments; Changes.** Within 30 days of execution or adoption, a managed care plan shall provide to the court the following amendments or changes.
1. Amendments to any of the contracts listed in Rule 57,A as well as amendments to any contracts previously provided with the application for certification.
 2. Changes in the managed care plan's ownership or organizational status, or the affiliation of the managed care plan with an insurer, risk management pool, or employer other than through a contract to provide management of treatment for injuries and diseases compensable under the Nebraska Workers' Compensation Act.
 3. Any other amendments to the certified managed care plan.
- C. Annual reporting.** In order to maintain certification, each managed care plan shall, with a nonrefundable fee of \$400, provide to the court within 30 days following each anniversary of certification the following information:

1. A current listing of participating health care providers, including names, clinics, addresses, telephone numbers, types of license, certification or registration, and specialties. The managed care plan must also submit a statement that all licensing, certification or registration requirements for the providers are current and in good standing in Nebraska or the state in which the provider is practicing.
2. A summary of any sanctions or punitive actions taken by the managed care plan against any of its participating providers.
3. A summary of any peer review, utilization review, reported complaints and dispute resolution proceedings showing cases reviewed, issues involved, and action taken.
4. Any other information requested by the court.

D. Data, Requested or Required. The managed care plan must report to the insurer, risk management pool, or self insured employer any data regarding medical, surgical, and hospital services related to a workers' compensation claim requested by the insurer, risk management pool, or self insured employer to determine compensability under the Nebraska Workers' Compensation Act and any other data required by statute or rule.

E. Monitoring. The court may monitor and conduct periodic audits and special examinations of the managed care plan as necessary to ensure compliance with the managed care plan certification and performance requirements. All records of the managed care plan and its participating health care providers relevant to determining compliance with Rule 51 through Rule 61, and sections 48-120 and 48-120.02, shall be disclosed within a reasonable time after request by the court. Records must be legible and cannot be kept in a coded or semicoded manner unless a legend is provided for the codes.

Sections 48-120.02, R.R.S. 2010, and 48-120, R.S. Supp., 2014.

Effective date: July 1, 1997.

RULE 58

MANAGED CARE DISPUTE RESOLUTION

- A.** Disputes that arise between the employee, health care provider, managed care plan, insurer, risk management pool, or employer, involving the question of inappropriate, excessive, or not medically necessary treatment, medical disputes, and those disputes listed under Rule 56,C shall first be processed without charge to the employee or health care provider through the dispute resolution procedure of the managed care plan. The managed care plan dispute resolution procedure must be completed within 30 days of receipt of a written request.
- B.** Under section 48-120.02, an employee shall exhaust the dispute resolution procedure of the certified managed care plan prior to filing a petition or otherwise seeking relief from the court on an issue related to managed care. If an employee has exhausted the dispute resolution procedure of the managed care plan, the employee may submit the dispute to the court for informal dispute resolution or may seek a medical finding by an independent medical examiner. No petition may be filed with the court pursuant to section 48-173 solely on the issue of the reasonableness and necessity of medical treatment unless a medical finding on such issue has been rendered by an independent medical examiner, but such finding shall not thereafter preclude the filing of a petition. A petition may be filed with the court for the purpose of avoiding the running of the applicable statute of limitations in which case the petition shall be deemed filed with the court for purposes of the statute of limitations and will be held in abeyance until the medical finding on the issue has been received from the independent medical examiner.

Sections 48-120.02, 48-134.01, 48-173, R.R.S. 2010, and 48-120, R.S. Supp., 2014.

Effective date: July 1, 1997.

RULE 59

MANAGED CARE

PEER REVIEW AND UTILIZATION REVIEW

- A. Peer review.** The managed care plan shall implement a system for peer review to prevent inappropriate, excessive, or not medically necessary treatment and to improve the quality of patient care and cost effectiveness of treatment. Peer review must include at least one health care provider of the same discipline being reviewed. The peer review must be designed to evaluate the quality of care given by a health care provider to a patient or patients. The plan must describe in its application for certification how the providers will be selected for review, the nature of the review, and how the results will be used.
- B. Utilization review.** The managed care plan shall implement a program for utilization review to prevent inappropriate, excessive, or not medically necessary treatment and to improve the quality of patient care and cost effectiveness of treatment. The program must include the collection, review, and analysis of group data to improve overall quality of care and efficient use of resources. In its application for certification, the managed care plan must specify the data that will be collected, how the data will be analyzed, and how the results will be applied to improve patient care and increase cost effectiveness of treatment.

Sections 48-120.02, R.R.S. 2010, and 48-120, R.S. Supp., 2014.

Effective date: July 1, 1997.

RULE 60

MANAGED CARE MEDICAL CASE MANAGEMENT

- A. Role of case manager.** A medical case manager in a managed care plan shall monitor, evaluate, and coordinate the delivery of quality, cost effective medical treatment and other health care services needed by an injured employee to assist him or her in reaching maximum medical improvement, and shall promote an appropriate, prompt return to work. Medical case managers shall facilitate communication between the employee, employer, insurer, risk management pool, health care provider, managed care plan, and any assigned vocational rehabilitation counselor to achieve these goals. The managed care plan must describe in its application for certification how injured employees will be selected for medical case management, the services to be provided, and who will provide the services.
- B. Qualifications of medical case manager.** A medical case manager, for purposes of a managed care plan, shall have attained the educational and/or employment experience set forth below in this rule. Acceptable case management experience must be full-time paid employment. Acceptable clinical experience involves full-time, paid employment either in a professional clinical setting (e.g., hospital/clinic, home health care, physician's private practice, etc.) or with a private rehabilitation firm. Additionally, professionally supervised internships, preceptorships, practica—whether paid or unpaid—may be counted toward meeting the full-time employment and clinical experiences. Volunteer work experience activities, however, may not be counted toward meeting the full-time employment or clinical experience requirements.
1. Designation of Certified Case Manager (CCM) by the Certification of Insurance Rehabilitation Specialists Commission for Case Manager Certification, or;
 2. Designation of Certified Insurance Rehabilitation Specialist (CIRS) by the Certification of Insurance Rehabilitation Specialists Commission, or;
 3. Current licensure as a Registered Nurse (RN), or;
 4. Current licensure as a Licensed Practical Nurse (LPN) and 18 months supervised clinical experience and six months acceptable case management experience, or;
 5. A baccalaureate degree (in a field other than nursing), current professional licensure or national certification in a health and human services profession, and at least 24 months employment experience, of which six months

must be acceptable case management experience and 18 months must be supervised clinical experience.

6. Extensive experience in medical case management may be substituted for any of the foregoing.

Sections 48-120.02, R.R.S. 2010, and 48-120, R.S. Supp., 2014.

Effective date: July 1, 1997.

RULE 61

MANAGED CARE SUSPENSION; REVOCATION

- A. Criteria.** The certification of a managed care plan may be suspended or revoked by the court if:
1. the plan for providing services or a contract with the insurer, risk management pool, self insured employer, or health care provider fails to meet the requirements of Rule 51 through Rule 61 or sections 48-120 and 48-120.02 or;
 2. service under the plan is not being provided according to the terms of the plan; or
 3. any false or misleading information is submitted by the managed care plan or participating provider; or
 4. the managed care plan continues to use the services of a health care provider whose license, registration, or certification has been suspended or revoked.
- B. Complaints; investigation.** Complaints pertaining to violations of Rule 51 through 61 or sections 48-120 and 48-120.02 by the managed care plan shall be directed in writing to the court. On receipt of a written complaint, or after monitoring the managed care plan operations, the court may investigate the alleged violation. The investigation may include, but shall not be limited to, request for and review of pertinent managed care plan records. If the investigation reveals reasonable cause to believe that there has been a violation, the certification may be suspended or revoked.
- C. Immediate Revocation.** Notwithstanding Rules 61,A and 61,B above, in any case where the court finds a serious danger to the public health or safety the court may immediately revoke the certification of the managed care plan.
- D. Effects.**
1. An employee is no longer required to receive services under a managed care plan if the managed care plan's certification is revoked.
 2. Any contractual obligations of an insurer, risk management pool, or self insured employer to allow a managed care plan to provide medical, surgical, or hospital services for employees pursuant to the Nebraska Workers' Compensation Act shall be null and void upon revocation of the certification of the managed care plan.

3. Any contractual obligations of a health care provider or other entity to deliver medical, surgical, or hospital services pursuant to the Nebraska Workers' Compensation Act, or to comply with any rules, terms, and conditions of the managed care plan or to make referrals into the managed care plan shall be null and void upon revocation of the certification of the managed care plan.

Sections 48-120.02, R.R.S. 2010, and 48-120, R.S. Supp., 2014.

Effective date: July 1, 1997.