THE INSIDER'S GUIDE:

What You Need To Know About New Jersey Workers' Compensation and Medical Cost Management

(What you don't know CAN hurt you!)

FIRST MCO

First Managed Care Option

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Introduction

Welcome to New Jersey! You will find it is a state like no other for so many reasons: the beautiful shoreline, the excitement of Atlantic City, the nostalgia of Springsteen's Stone Pony in Asbury Park, and much more. But if you run a business, it is also very important to know about another thing that makes New Jersey unique – its workers' compensation system.

Specifically, there are three very important distinctions for New Jersey Workers' Compensation:

- New Jersey is one of a few states with NO fee schedule;
- New Jersey is one of a few states where the employer and/or agent can direct care for the life of the workers' compensation claim; and
- Any injured employee's failure to comply with employer and/or agent-directed care can result in a loss of benefits.

These and other regulatory aspects make New Jersey's workers' compensation system different from those of other states – and those details can make an enormous difference in the way you manage your company's program to ensure compliance, maintain efficiency, and protect your financial investment.

For this reason, First Managed Care Option, Inc. (dba First MCO) has compiled this brief, user-friendly guide to help you better understand the complexities of New Jersey's workers' compensation system, make the best coverage decisions for your business and employees, and optimize the management of your own program – all while saving you time and money.

Our goal is for you to develop a solid understanding of the requirements and care options your organization has, establish the structure you need, and achieve the quality standards you deserve. In doing so, you'll be better positioned to devote your time to your top priority...your business.

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SECTION I:

NEW JERSEY'S WORKERS' COMPENSATION BASICS & UNIQUE ASPECTS

THE BASICS

New Jersey is a pioneer in the area of workers' compensation, with a system that has provided benefits to injured workers for more than 100 years. As a key manufacturing state in the early 1900s, New Jersey was the first to create an Employers' Liability Commission in 1910 to include business, labor, and legislative representatives. This Commission was responsible for examining employer liability/worker compensation issues, and reporting their findings as a key part of establishing a formal employers' liability act.

The members of the Commission were unanimous in their belief that workers' compensation to legitimately injured employees should be a matter of justice, and thus proposed statutory language for a comprehensive program to meet the needs of both employers and the workforce. As such, both injured employees and their employers would be protected – injured workers would receive the compensation and care needed to recover/be made whole, and employers would be protected against costly litigation seeking such compensation.

Today, every state in the nation has since adopted some form of workers' compensation legislation, and New Jersey's system continues to evolve and meet the needs of an ever-changing economy. By developing new innovations and streamlining efficiencies, New Jersey's workers' compensation system continues to provide fair and progressive benefits to injured workers, while maintaining appropriate cost containment provisions to ensure competitive insurance rates.

The system's current laws and regulations were established under the New Jersey Workers' Compensation Act (N.J.S.A. 34:15-1 et seq.), and are administered by the Division of Workers' Compensation that is responsible for:

- Ensuring that workers receive fair and timely workers' compensation benefits for work-related injuries from their employers and/or insurance carriers;
- Enforcing the law that requires employers to secure workers' compensation insurance coverage from commercial insurance carriers or self-insurance programs; and
- Providing certain benefit payments to injured workers who are totally and permanently disabled as a result of their pre-existing disabilities. These benefits commence at the conclusion of the payment benefits from the worker's employer.

A NOTE ABOUT RATES:

The New Jersey Compensation Rating and Inspection Bureau of the Department of Banking and Insurance (NJCRIB) is charged by Statute to establish and maintain rules, regulations and premium rates for workers' compensation and employers liability insurance.

To learn more, visit:
www.njcrib.com/ReferenceGuide/cribcnst.ast

Who is Covered under New Jersey's Workers' Compensation?

By law, virtually every worker in New Jersey who performs services for wages is to be covered by workers' compensation, regardless of the number of workers employed by the employer. There are certain industries and situations with exceptions to the rule including:

- Domestic and farm workers are covered. However, workers considered to be independent contractors (rather than employees) are not covered.
- Seamen, maritime workers, railroad workers, and federal employees are covered under federal workers' compensation law rather than state law.

IT'S IMPORTANT TO KNOW: The New Jersey Workers' Compensation Act is liberally interpreted with respect to the definition of "employee" and is broader than the Internal Revenue Code and Unemployment Compensation statute. See "Definition of Employee" in Section II: Insurance Requirements for more information.

What Medical Benefits are Covered by Workers' Compensation Insurance?

If an employee is injured on the job, the employer's insurance carrier is responsible for all necessary and reasonable medical treatment, prescriptions and hospitalization services related to the work injury. In cases where the employer is self-insured, the employer is responsible for the same expenses.

NOTE: In the state of New Jersey, the employer and/or agent has the right to designate the authorized treating physician for all work-related injuries. An injured worker may choose the treating physician ONLY IF the employer inappropriately refuses to provide medical treatment, or in an emergency situation. In such emergencies, the injured worker should notify the employer as soon as possible regarding any treatments being received.

Read the Fine Print Below:
The Official Statute on Medical Benefits Under Workers' Compensation Law

Medical and hospital service (N.J.S.A. 34:15-15.). *The employer shall furnish to the injured worker such medical, surgical and other treatment, and hospital service as shall be necessary to cure and relieve the worker of the effects of the injury and to restore the functions of the injured member or organ where such restoration is possible; provided, however, that the employer shall not be liable to furnish or pay for physicians' or surgeons' services in excess of $50.00 and in addition to furnish hospital service in excess of $50.00, unless the injured worker or the worker's physician who provides treatment, or any other person on the worker's behalf, shall file a petition with the Division of Workers' Compensation stating the need for physicians' or surgeons' services in excess of $50.00, as aforesaid, and such hospital service or appliances in excess of $50.00, as aforesaid, and the Division of Workers' Compensation after investigating the need of the same and giving the employer an opportunity to be heard, shall determine that such physicians' and surgeons' treatment and hospital services are or were necessary, and that the fees for the same are reasonable and shall make an order requiring the employer to pay for or furnish the same. The mere furnishing of medical treatment or the payment thereof by the employer shall not be construed to be an admission of liability.*

If the employer shall refuse or neglect to comply with the foregoing provisions of this section, the employee may secure such treatment and services as may be necessary and as may come within the terms of this section, and the employer shall be liable to pay therefore; provided, however, that the employer shall not be liable for any amount expended by the employee or by any third person on the employee's behalf for any such physicians' treatment and hospital services, unless such employee or any person on the employee's behalf shall have requested the employer to furnish the same and the employer shall have refused or neglected so to do, or unless the nature of the injury required such services, and the employer or the superintendent or foreman of the employer, having knowledge of such injury shall have neglected to provide the same, or unless the injury occurred under such conditions as make impossible the notification of the employer, or unless the circumstances are so peculiar as shall justify, in the opinion of the Division of Workers' Compensation, the expenditures assumed by the employee for such physicians' treatment and hospital services, apparatus and appliances.

All fees and other charges for such physicians' and surgeons' treatment and hospital treatment shall be reasonable and based upon the usual fees and charges which prevail in the same community for similar physicians', surgeons' and hospital services.

When an injured employee may be partially or wholly relieved of the effects of a permanent injury, by use of an artificial limb or other appliance, which phrase shall also include artificial teeth or glass eye, the Division of Workers' Compensation, acting under competent medical advice, is empowered to determine the character and nature of such limb or appliance, and to require the employer or the employer's insurance carrier to furnish the same.

Fees for treatments or medical services that have been authorized by the employer or its carrier or its third party administrator or determined by the Division of Workers' Compensation to be the responsibility of the employer, its carrier or third party administrator, or have been paid by the employer, its carrier or third party administrator pursuant to the workers' compensation law, R.S.34:15-1 et seq., shall not be charged against or collectible from the injured worker. Exclusive jurisdiction for any disputed medical charge arising from any claim for compensation for a work-related injury or illness shall be vested in the division. The treatment of an injured worker or the payment of workers' compensation to an injured worker or dependent of an injured or deceased worker shall not be delayed because of a claim by a medical provider.

WHAT MAKES THE NEW JERSEY WORKERS' COMPENSATION SYSTEM UNIQUE?

Certain regulatory aspects make New Jersey's workers' compensation system different from those of other states – and those details can make an enormous difference in the way you manage your company's program to ensure compliance, maintain efficiency, and protect your financial investment.

Specifically, three very important distinctions exist in New Jersey's Workers' Compensation rules:

- New Jersey is one of a few states with NO FEE SCHEDULE;
- New Jersey is one of a few states where the employer can direct care for the life of the workers' compensation claim; and
- Any injured employee's failure to comply with employer-directed care can result in a loss of benefits.

What are the implications of having no fee schedule?

New Jersey has some of the most expensive medical care costs in the nation. Health care networks are under a great amount of pressure due to Medicare limitations and existing fee schedules for auto insurance claims, thus leaving the area of workers' compensation a welcome area for providers to operate under few, if any, constraints.

In cases where providers do not belong to a network, most often times repricing organizations will automatically reduce providers' billing to the "usual and customary" fees published by entities such as FairHealth and Wasserman. In doing so, the intention is to pay providers a fair balance between what they may have billed, and what is considered a reasonable fee to pay for the service(s)...however the providers do not have to accept that payment and can dispute the amount.

As such, the state of New Jersey provides a separate track in its workers' compensation court devoted solely to billing disputes so that they may be resolved quickly while the remainder of the case continues through the process.

What are the implications of having direction of care?

The employer and/or agent and their designated managed care provider have control of the claim, and can then direct the claimant to a known provider (usually orthopedic or occupational medical doctors which are relevant to the majority of cases) who will:

1) Interview the patient to find out more about the accident;
2) Communicate with you, the employer, throughout the treatment;
3) Share their notes and discuss a return to work plan;
4) Understand the goals of worker's compensation; and
5) Direct care to other providers, surgi-centers or hospitals that you approve as necessary.

In the state of New Jersey, the employer and/or agent has the right to designate the authorized treating physician for all work-related injuries. Therefore, if the patient (injured employee) does not go to the provider that is designated by the employer and/or agent, the employer has the right to deny payment to that provider, and cut off **ALL** benefits to the injured employee.

The Bottom Line

The key to building a successful provider network (and thus a strong, competent workers' compensation system) in New Jersey is to help providers understand that Managed Care Organizations, and employer representatives, have the ability to direct business *TOWARD* them, or away from them.

Once providers develop an understanding of this concept, physicians will seek to join the network, and compete to be the best providers. As such, they will also become competitive with pricing. Often, out-of-network providers are dissatisfied with the "usual and customary" repricing of their billing when the business was not refered to them – in these cases, they believe they should be fully compensated. However, once patients are being directed *toward* their practices, providers will, in turn, become more competitive than most state fee schedules dictate in order to secure additional business.

Therefore, when you provide workers' compensation services in New Jersey, it is imperative to utilize a strong, and actively directed network.

In the state of New Jersey, strong case management makes for a strong network.

SECTION II:

INSURANCE REQUIREMENTS

All employers in the state of New Jersey who are not covered by federal workers' compensation programs are required by law to have workers' compensation coverage or be approved for self-insurance. But businesses are structured in so many different ways today, with unique working arrangements and in different locations -- so it's important to make sure you're covered.

My business is not located in New Jersey. Why would I need coverage?

By law, out-of-state employers may need to obtain workers' compensation coverage if a contract of employment is entered into in New Jersey, or if the work is performed in the state.

WORKERS' COMPENSATION INSURANCE: WHO NEEDS IT?

If you're a business in New Jersey with employees...YOU do. State law requires that all New Jersey employers not covered by federal programs have workers' compensation coverage or be approved for self-insurance. Regardless of size, type, or industry, businesses and entities that employ workers must have workers' compensation insurance in effect in the state of New Jersey, including those classified as:

Corporations – All corporations operating in New Jersey must maintain workers' compensation insurance or be approved for self-insurance so long as any one or more individuals, including corporate officers, perform services for the corporation for prior, current or anticipated financial consideration.*

Partnerships/LLCs – All partnerships and limited liability companies (LLCs) operating in New Jersey must maintain workers' compensation insurance or be approved for self-insurance so long as any one or more individuals, excluding partners or members of the LLC, perform services for the partnership or LLC for prior, current or anticipated financial consideration.*

Sole Proprietorships – All sole proprietorships operating in New Jersey must maintain workers' compensation insurance or be approved for self-insurance so long as any one or more individuals, excluding the principal owner, performs services for the business for prior, current or anticipated financial consideration.*

*Financial consideration means any remuneration for services and includes cash or other remuneration in lieu of cash such as products, services, shares of or options to buy corporate stock, meals or lodging, etc. ***In short -- if you're paying someone, bartering for goods or services, or trading anything of value for something they provide to you/your business...you are required by law to obtain workers' compensation insurance in the state of New Jersey.***

So if Workers' Compensation Insurance is Required, What are the Options for Coverage?

Businesses have two options for securing workers' compensation insurance in the state of New Jersey, which may be obtained with either of the following types of coverage:

Option 1: Workers' Compensation Insurance Policy
This type of policy is written by either a mutual or stock carrier who is authorized to write insurance in the state of New Jersey. Premiums for such insurance are based on the classification(s)* of the work being performed by employees, the claims experience of the employer, and the payroll of the employer.

(*See more about the classification system in the "Insurance Premium Rates" section that follows.)

Option 2: Self-Insurance
This coverage option requires an application to and approval by the Commissioner of the Department of Banking and Insurance. Approval for self-insurance is based upon the financial ability of the employer to meet its obligations under the law and the permanence of the business. The posting of security for such obligations may be required.

A NOTE ON SELF-INSURANCE OPTIONS: Once approved by the Commissioner of the Department of Banking and Insurance, a self-insured employer can administer his/her own workers' compensation claims, or contract with a third-party administrator (TPA) to provide these services.

For more information about self-insurance, employer eligibility, and procedures, please refer to N.J.S.A. 34:15-77 of the New Jersey Workers' Compensation statute or contact the Department of Banking and Insurance at (609) 292-5350, ext. 50099.

Option 3: Coverage Option Available Only to Governmental Agencies
Like businesses, governmental agencies are also required to provide workers' compensation benefits to their employees. However, they are not required to purchase insurance or receive approval as a self-insurer. Governmental agencies typically utilize one of the three following options for coverage: (1) obtain an insurance policy, (2) participate in an insurance pool, or (3) maintain a separate appropriation for workers' compensation.

AN IMPORTANT DISTINCTION REGARDING "EMPLOYEE" STATUS IN NEW JERSEY

I have workers that are not technically employees (consultants and/or volunteers). That makes me exempt from having to provide workers' compensation insurance for them, right?

WRONG. The New Jersey Workers' Compensation Act is liberally interpreted with respect to the definition of "employee" and is broader than the Internal Revenue Code and Unemployment Compensation statute. A variety of working relationships have been determined to be that of employer-employee, including some that would not appear to be a typical employment situation. So just because they may not be considered employees by you (or even other states), you cannot assume you will be exempt from providing workers' compensation insurance for those individuals.

Learn more regarding this important distinction in the "Definition of Employee" section that follows, and by visiting http://lwd.dol.state.nj.us/labor/forms_pdfs/wc/pdf/wc_law.pdf

DEFINITION OF "EMPLOYEE"

In the state of New Jersey, the definition of "employee" with regard to the New Jersey Workers' Compensation Act is different than many other states, and has a broader definition than that of the Internal Revenue Code and Unemployment Compensation statute. Some working relationships that might not be considered traditional "employer-employee" have been deemed as such in New Jersey, and contracts or other agreements classifying individuals as "non—employees" or similar are not binding in the state's determination of whether an employee-employer situation exists.

PUTTING CONTRACTS TO THE TEST: HOW IS "EMPLOYEE" STATUS DETERMINED?

In deciding this issue, the New Jersey courts have developed two tests to determine whether a worker is classified as an "employee" (and thus, requiring workers' compensation coverage):

1. ***The "Control Test"***
   The relationship between a business and the individual is reviewed; if the business retains the right to supervise the individual, control what is done and how it will be done, the agreement constitutes employment.

2. ***The "Relative Nature of the Work Test"***
   If an individual relies on income from the business and the work performed by that person is an integral part of the business' activities, the agreement constitutes employment.

In short, if any or both of these tests are met, an employee-employer relationship is therefore established and the employer is required to provide workers' compensation insurance coverage.

OBTAINING WORKERS' COMPENSATION COVERAGE: WHERE TO BEGIN

More than 400 privately licensed insurance companies are currently authorized to sell workers' compensation policies in the state of New Jersey, and policies can be purchased directly from an insurance carrier, an insurance agent, or an insurance broker.

In order to aid and protect employers, the New Jersey Compensation Rating and Inspection Bureau (NJCRIB), an agency in the New Jersey Department of Banking and Insurance, establishes and maintains premium rates, regulations, and ratings programs for workers' compensation and employers' liability insurance carriers. For questions or assistance with obtaining coverage, please contact:

New Jersey Compensation Rating and Inspection Bureau
60 Park Place
Newark, NJ 07102
www.njcrib.com
(973) 622-6014

INSURANCE PREMIUMS: HOW RATES ARE ESTABLISHED

No two businesses are the same.
How can I be sure that my business is being charged fairly?

The New Jersey Compensation Rating and Inspection Bureau (NJCRIB) is charged with the responsibility of establishing and maintaining premium rates, and has established a multi-level classification system which serves as the primary device in determining workers' compensation insurance premiums:

- First, the classification system groups New Jersey businesses into various categories, in which employers who are engaged in the same type of business are grouped within each classification;
- Next, each classification rate takes into account the average work-injury experience for that classification, and is further adjusted each year according to the latest available work-injury experience data.
- NJCRIB further recognizes that no two employers, although they may be in the same business, have exactly the same operations or identical conditions of employment. Some have better-than-average work injury experience, while some others may have experience considered to be worse-than-average. Therefore, within any given classification, additional refinements are made through a program called the Experience Rating Plan.
- The Experience Rating Plan can then modify premiums (either higher or lower) by comparing an employer's work injury experience to the average of all those employers within the same classification.

For more detailed information on how rates are established, you may wish to read the WC Reference Guide available on NJCRIB's Web site (www.njcrib.com/ReferenceGuide/cribcnst.asp).

What are the minimum benefits that should be covered by my workers' compensation policy?

For injured employees:

- Reasonable medical services necessary to treat the job injury or illness
- Temporary disability benefits to help replace lost wages up to statutory maximum
- Permanent disability benefits to compensate for the continued effects of the injury
- Burial and death benefits for dependents in cases of fatal injury

For employers:

- Coverage of financial liabilities for work-related injuries and illnesses
- Legal representation

Want to Reduce Your Insurance Premium?

Employers should look for an insurer who offers a certified managed care organization that is approved by the Department of Banking and Insurance. By doing so, the employer is eligible to receive a premium discount of 5% or more!

New Jersey's Workers' Compensation Law (N.J.S.A. 34:15-1 et seq.) permits employers to select providers of medical services for injured workers. As an alternative to the traditional approach to workers' compensation coverage, employers may opt to utilize a managed care system for the delivery of quality medical care to injured employees at a reduced premium. Thus, employers will be eligible to receive at least a five percent reduction in policyholder standard premium by selecting the managed care option offered by the employer's workers' compensation insurer if the insurer uses a Department approved MCO.

Learn more in the "Quality Check" section on page 19!

IS WORKERS' COMPENSATION INSURANCE REALLY NECESSARY?

My business isn't really prone to accidents...so what if I just skip buying the insurance and pay for any potential employee injuries out of my own pocket?

Don't even consider it. The consequences for failure to provide workers' compensation coverage can be very significant, even without a work-related injury. Specifically, the law provides that failing to insure is a disorderly persons offense and, if you're determined to be knowing, a crime of the fourth degree.

Moreover, penalties for such failure can be assessed up to $5,000 for the first 10 days with additional assessments of $5,000 for each 10-day period of failure to insure thereafter. In the case of a corporation, liability for failure to insure can extend to the corporate officers individually. Penalties assessed for failure to insure are not dischargeable in bankruptcy.

...and what if I'm not insured and someone gets hurt?

Where a work-related injury or death has occurred, the employer, including individual corporate officers, partners or members of an LLC, is directly liable for medical expenses, temporary disability, and permanent disability or dependency benefits.

In addition to awards for medical expenses and other benefits, New Jersey law also provides for civil penalties against the employer and its officers where failure to insure is determined. Awards and penalties arising from these claims can become liens against the uninsured employer and its officers, which are generally enforceable in the New Jersey Superior Court against any assets belonging to the uninsured employer and its officers.

The Bottom Line

Not only is it the law to provide workers' compensation coverage for employees, but this insurance protects not just your business – but any business owner(s) and corporate officers' personal assets as well. Failing to insure is not a gamble worth taking for many reasons.

SECTION III:

COMPARING YOUR OPTIONS – MANAGED CARE SERVICES AND NETWORK ACCESS

The New Jersey Workers' Compensation system has been helping to protect workers for more than a century, continually evolving to adapt to the ever-changing workplace. Today, all employers in the state of New Jersey who are not covered by federal programs are required by state law to provide workers' compensation coverage or be approved for self-insurance.*

Unlike the workers' compensation systems of most traditional "File and Use" states, New Jersey's is a "Bureau State," and unique in that there are no fee schedules, and employers and/or their agents can direct care for the life of each workers' compensation claim.

In essence, this places New Jersey's employer and/or agents in charge of:

- selecting health care providers for any injured employee(s);
- managing the direction of those injured employee(s) care;
- coordinating all doctor visits for any injured employee(s);
- ensuring any employee(s) recovery allows for their safe return to work; and
- coordinating re-entry for those employee(s) return to the workplace.

Regardless of whether the employer is covered by an outside insurance agency or self-insured, they have two basic options for helping to fulfill those health-related needs for their injured employee(s):

- A Certified Managed Care Organization*
- A Provider who is part of a Certified Managed Care Network

*Certification is needed only if the company offers a managed care premium discount.

A Brief History on How We Got Here

In the late 1970s, healthcare provider organizations (managed care) began pairing "case managers" with their patients with the goal of coordinating care and promoting better outcomes. In the workers' compensation arena, it was found that these HMO-type models began showing promise in helping injured workers recover and return to work in a more timely fashion.

By the 1980s, industry leaders including InterCorp, Corvel, and First Health began to expand those provider networks by partnering with contracted medical centers in order to gain a competitive edge in both coordinating patient treatment(s) and securing more competitive pricing on claims.

Similarly, the PPO Networks (In-Network providers) began establishing networks in the 1970s by contracting with independent providers who would agree to a set of business/care standards, and adhere to the established pricing guidelines for their services.

In 1993, the New Jersey Managed Care Organization was formally adopted. Its purpose was (and remains today) twofold. First, it to encourage the use of managed care to furnish injured workers with the medical, surgical and other treatments -- including hospital care -- necessary to cure and/or relieve the injured worker of the effects of the injury. Second, its purpose is to help contain medical costs under workers' compensation coverage by providing eligible employers with a method in which they can receive a reduced premium by selecting a managed care alternative option in lieu of the traditional workers' compensation medical care model.

By the 2000s, the managed care model had evolved to include a broad selection of health services that promoted a treatment/delivery/pricing strategy for Self-Insurers and Insurance companies alike. This model created a cafeteria industry of services from which to select, and further encouraged workers' compensation claims handling that were successful from both the health care and economic aspects.

Among the most successful strategies were those that directed any and all ancillary claim services to a Managed Care Service Provider that is contracted for both business/care standards and pricing. Today, those strategies continue to remain at the forefront of successful managed care programs, which are coordinated throughout the entire claims payment process and incorporated into existing claims systems. This network access is a keystone in any successful Managed Care strategy.

In contrast, the PPO network model has remained dependent upon the claim process at the adjuster level to appropriately channel or refer claimants to Network Providers. As such, the industry has seen an increasing number of occupational medical centers working under a "pay for play" model – one in which patients are managed for free, but operate under a system where the more treatments are provided, the more they are paid. It is a model that financially rewards over-treatments.

***IMPORTANT NOTE:** See section II: Insurance Requirements for important, detailed information regarding coverage regulations unique to the state of New Jersey, including those specific to out-of-state employers and contract workers.

Quality Check

SPECIAL CERTIFICATION IS REQUIRED IN NEW JERSEY FOR MANAGED CARE ORGANIZATIONS TO PROVIDE TREATMENT FOR WORKERS' COMPENSATION CASES IF A PREMIUM DISCOUNT IS OFFERED

It is a regulatory requirement in the state of New Jersey that any workers' compensation insurer who wishes to qualify for offering reduced premiums to employers must first obtain a Workers' Compensation Managed Care Organization (WCMCO) status through the New Jersey Department of Banking and Insurance.

As part of this certification, the Department must find that the Managed Care Organization is capable of providing the necessary types of care to treat workplace-related injuries and diseases.

Once the WCMCO applicant (organization) has met the approval criteria set forth in the rules, it may then enter into a written agreement with an insurer to provide medical services under a workers' compensation insurance policy.

Any insurer willing to offer a premium reduction to employers after they have contracted with a Department-approved WCMCO is then required to file certain information with the New Jersey Compensation Rating and Inspection Bureau (NJCRIB). These insurer filing requirements are set forth in the CRIB Manual, available at: www.njcrib.com/manual/

At the completion of both requirements, the workers' compensation insurer may then implement the Managed Care program by offering employers a Managed Care Program Policy Endorsement that has been developed by NJCRIB. That endorsement will reduce the employer's premium by five percent (5%) or more.

Those organizations who wish to be approved as WCMCOs must submit a formal application to the New Jersey Department of Banking and Insurance and comply with all rules applicable to WCMCOs. To view the application, please visit: www.state.nj.us/dobi/division_insurance/managedcare/wc_app.pdf

SECTION IV:

WHAT YOU SHOULD EXPECT FROM A MANAGED CARE ORGANIZATION

In the open economy, there are numerous available options when selecting a Managed Care Organization (MCO) for workers' compensation needs. While each MCO can be unique in its provider selection, strengths, and business practices, there are a number of important personnel, responsibilities, and elements that you should have, and expect, as a part of quality coverage:

Experienced Case Manager(s)

A case manager will provide a number of critical functions during the administration of any Workers' Compensation claim. The case manager should be a **nurse, whose initial responsibility is to make four-points of contact within 24 hours of any claim to include:**

1) ***The injured employee.*** The nurse case manager's first contact will be with the injured employee to discuss and obtain a thorough medical history, including all aspects inclusive of and related to the accident, and the mechanism of injury (details such as a description of the injury, details related to location injury occurred, potential witnesses, and prior medical history that may be relevant in determining the patient's health status and habits prior to the injury).

2) ***The employer.*** Then, the nurse case manager will contact the employer to:
   - review the accident;
   - interview witness(es) if any;
   - discuss the patient's job description; and
   - request a written copy of the job description (including specific duties such as lifting more than 50 pounds, standing for 12 hours per day, etc.).

3) ***The provider.*** It is the nurse case manager's responsibility to contact the injured worker's treating physician within 24 hours of their visit to obtain an update, which should include:
   - provider's objective findings;
   - subjective complaints made by the patient;
   - treatment plan; and
   - requests for additional tests or services (e.g.: x-rays, physical therapy, etc.).

   The nurse case manager will then:
   - direct patient care toward an in-network provider;
   - secure treatment(s) from qualified physicians familiar with workers' compensation procedures; and
   - ensure patient progress and that proper protocols are met.

4) ***The claim adjuster.*** The nurse case manager remains in continuous communication with the claims adjuster to keep them updated on patient treatment(s) and seek authorization(s) as necessary. In addition, the nurse case manager provides the claims adjuster with any information needed related to the patient's return to work status.

In a Nutshell: Your Nurse Case Manager's Process & Responsibilities

1. Contact injured employee to secure accident details & employee's medical history
2. Contact employer to review accident & secure employee's job description
3. Contact treating physician for findings & proposed treatment plan, direct patient care to in-network providers
4. Keeps claims adjuster in the loop throughout the process for necessary authorizations & patient progress updates

Quality Provider(s) with an Understanding of Workers' Compensation Intricacies

Employees are a critical component to any business, and employers need to protect them like any other asset. For that reason, a quality managed care organization should possess a knowledgeable network of providers who are skilled in various specialties, and also well versed in workers' compensation practices.

In doing so, the employee, employer, and claim adjuster can move through the process in a productive and efficient manner, using skilled providers who provide the following benefits:

- Familiarity with the unique situations that workers' compensation injuries can present;
- Understanding the need to follow protocols for a comprehensive interview process;
- Knowing how such protocols are used in providing a sound foundation for case files;
- An office staff prepared to return information regarding patient visits within 24 hours;
- Being available to the nurse case manager and/or adjuster as needed;
- Having the ability to address patients' abilities at each visit, thus allowing the nurse case manager to work with the employee to encourage/accommodate a safe return to work;
- Ability to provide a patient history that describes any physical factors and/or appropriate medical history that may have contributed to the injury; and
- Ability to document all objective findings that are reached by reproducing such findings in an exam (may include but not limited to functions such as bending, squatting, movement of extremities, grip strength, etc.).

In using a network of qualified providers who are experienced in workers' compensation, its administrative processes, the entire "team" -- patient, physician(s), nurse case manager, employer, and claims manager -- can work together efficiently toward the mutual goal of helping the patient heal properly and safely return to work as soon as they are able.

Detail-Oriented Bill Review Service

In the quest to utilize a quality managed care organization and also contain costs, the bill review company plays an important role in the process. It is their responsibility to review and scrutinize every patient bill from every provider to ensure that they are accurate, treatments are appropriate, and no errors are overlooked in the process. During such, the bill review process should follow the procedural guidelines below for each provider invoice in order to ensure accuracy throughout the billing process:

- Providers submit a bill, along with the appropriate documentation detailing the services provided at that visit;
- Bills are reviewed for content, and appropriate coding for level(s) of service;
- Medical necessity and causal relation to the injuries sustained in the workers' compensation incident is validated;
- All coding edits, including AMA guidelines, NCCI edits, and Medicare guidelines, are applied;
- Any unrelated services are recommended for non-payment; and
- The bill review service should supply the party responsible for bill payment (TPA, employer or insurance carrier) and the provider with an Explanation of Review (EOR) for every bill that is processed; the EOR will include distinct explanations as to how the bill was repriced, and information needed by the provider in case of questions.

What happens if a provider disagrees with the repricing adjustments to a bill?

The bill review service/company should handle any and all appeals from providers regarding bills that were processed. They should be able to explain and defend their results with proven data as it relates to their edits.

Hospital bills can be very complex; how are those handled?

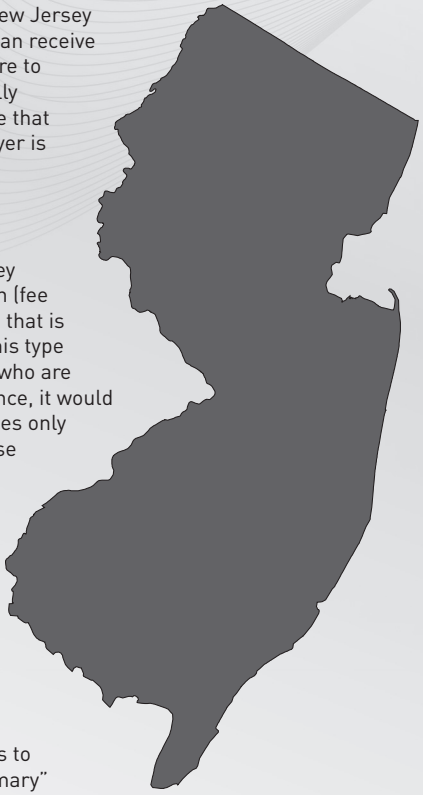
For any hospital bill or in-patient stay, an extensive, line-by-line review should be conducted to identify and exclude (scrub) any unrelated services and/or medications provided during the patient's stay. Anesthesia and surgical bills should be taken through an extensive review process during which specialty-trained surgical/anesthesia reviewers also review/scrub the bill for proper coding.

Network

In evaluating provider-based networks, you will want to select one that has an experienced and expansive medical network, and one that adheres to strict credentialing and medical guidelines designed to return an injured worker to productive employment. It is also important to look for a network constructed by both medical and claims professionals who understand and are experienced in treating workers' compensation-specific illnesses and injuries in order to achieve return-to-work goals at the fairest cost. These outcome-based networks, in particular, better enable employer and/or agents to recognize and access those providers who consistently demonstrate practice care and outcome patterns that deliver the best patient and claim outcomes for all employees and employers alike.

Important:

Things to Know When Choosing a Network in New Jersey



Most workers' compensation Networks in New Jersey are considered passive – which means you can receive discounted services without directing the care to the provider. These networks are traditionally provided through a national repricing service that "stacks" networks to ensure that the employer is consistently receiving discounted billings.

Often times, these passive networks provide a false sense of savings in the state of New Jersey, because providers are aware that they are not receiving "true" referrals or direction (fee structure), and can therefore negotiate a fee that is high enough to avoid the appeal process. This type of arrangement is often set up by providers who are offering a 50% discount off a bill. So in essence, it would be similar to a retailer marking up their prices only to put them on sale (and provide a false sense of savings). At the outset, it appears to be a significant discount until you realize the bills are being doubled in anticipation of the impending reduction. To further complicate the issue, repricers don't necessarily take issue with this practice because they may make profit on the savings, and/or show that they have reduced the bill as part of their bill review process.

The only way to properly assess a Network is to compare its results to the "usual and customary" standard. If you choose a program that uses "stacked" networks, you will have a program that has little or no case management.

Pharmacy Benefits

The pharmacy benefit is an important component in any workers' compensation coverage. Under workers' compensation, a pharmacy management network is specifically designed to ensure that injured worker(s) obtain the appropriate amount of medication at a fair unit price. This benefit helps manage patient care by:

- Preventing patient overuse of any prescribed medications;
- Avoiding prescription mis-fills/verifying accuracy of medication(s);
- Avoiding early or unnecessary medication refills; and
- Avoiding payment for unrelated medications.

Optimally, a quality pharmacy benefit program should include a national network that is designed to facilitate rapid response and procurement of medication necessary to treat injured worker(s) at the pharmacy. In addition, the program should include a mail order/home delivery program that is available in the case of long-term treatment of extended or catastrophic injuries.

Information Technology (IT) Personnel

Clear communication is critical to both modern medical care and the workers' compensation system. In order for either to function most effectively, they should have the technology infrastructure and related support to ensure patient safety, streamline operations, support physicians, inform claims personnel, and more.

It is important to have a workers' compensation plan that can support your business throughout the claims process, and include expert Information Technology (IT) personnel with the necessary knowledge and experience in HIPAA, EHRs, coding, billing systems, support and more.

Adjuster

Adjusters play a key role in helping to manage workers' compensation costs. They should possess a wide range of experience in the workers' compensation arena, which provides them with knowledge of (and exposure to) potential problems and inefficiencies that can result in costly delays and unnecessary and/or improper treatment(s). This solid base of knowledge enables adjusters to implement the best and most effective practices for injured employees, while also controlling costs to the employer.

SECTION V:

A SUCCESSFUL PROGRAM – IMPACT AND VIEWPOINTS

As it's often been said, "beauty is in the eye of the beholder." The same can be said for employing a successful workers' compensation program, particularly when it comes to operating a business in the state of New Jersey. There are a number of business benefits to utilizing a successful managed care program, many of which can vary depending upon the individual's viewpoint and/or company's division. Some of the leading benefits include:

Executive Level

Cost reduction. A successful managed care program will help your business yield a cost-reduction below national standards by lessening Temporary Total Disability (TTD) payments, and reducing overall costs due to injured workers' lost time from work. Upper management is primarily responsible for the financial results of a company, and a managed care program will help control expenses.

Director Level

Smoother operations. Claims are regularly updated when a managed care program is in place, leaving director(s) up-to-date regarding employee status. Directors are provided with comprehensive reporting so they have an ongoing status reports from the injured employee, physicians, and claims adjuster which helps them to ensure proper medical care is being provided to help the employee return to work safely. Directors are also able to request custom reporting as desired to help manage operations and workflow, request additional information, and more.

Information Technology (IT) Level

Legal and regulatory compliance (and fewer headaches). Today's medical care management system is extremely complex and comes with a number of legal and regulatory requirements, demanding more of than ever of Information Technology (IT) systems. Having the benefit of a quality managed care program ensures that your business is armed with a team of qualified IT professionals who stay current on all legal and regulatory requirements, HIPAA issues, Electronic Health Record (EHRs) aspects, patient privacy issues, and more. For example, a managed care organization abides by stringent auditing standards endorsed by the American Institute of Certified Public Accountants (AICPA), which includes Statements of Standards for Attestation Engagement (SSAE 16), to ensure the level of security and compliance you need. (To learn more about SSAE 16, visit http://ssae16.com.) Having this dedicated team of specialists allows your company's own IT personnel to focus on your business as a whole, rather than dedicating countless man hours trying to stay up-to-date on this singular workers' compensation aspect.

Human Resources Level

Improved personnel management. Workers' compensation aside, managing the human resources aspect of any business comes with its own challenges. If an employee is injured, however, that aspect becomes even more complex because it impacts not only the well-being of that employee, but can also affect the business' productivity, staffing needs, training needs, outsourcing, and more. On a more personal level, it can potentially impact the employee-employer relationship once other factors are introduced (i.e.: employer and/or agent becomes involved in employee's health care, potential impact(s) to the income and/or benefit stream, sense of feeling (real or imagined) pressure to return to work to soon, etc.). A quality managed care system is systematically designed to enables all stakeholders to function as a team with the sole purpose of helping the employee safely return to work and resume his/her life as before. This team-based approach helps to guide the entire recovery process, making it more efficient, helping manage costs, making the process less adversarial in nature, and allowing for more effective management of the company's human resources as a whole.

Adjuster Level

Added levels of support and experience. A quality managed care program provides in-company adjusters with an additional level of support and a broad range of experience to ensure that workers' compensation claims are handled correctly, accurately, and in a timely manner. This level of support expands the in-house adjusters' abilities to manage costs by avoiding unnecessary charges and/or overpayment(s), accurately ascertaining all details of any incident/situation, determining the most effective and appropriate course(s) of action for injured employee(s), developing a return-to-work plan, and remedying any potential hazards to prevent future injuries and protect the company's investments.

TRUE CONFESSIONS ON WORKERS' COMPENSATION: Part One

The Adjuster: "It's Just an Awful Lot to Manage"

"I know it's my job to be the case manager for every workers' compensation claim, but it sure does create a lot of extra work and I'm already too busy. I have to choose the providers, request notes from doctors, schedule patient visits, follow-ups, labwork and more...and I'm not sure my training is adequate for all of this responsibility."

"I'm trying to do it all, but not always able to keep up. Many times, our employee's doctor is making recommendations for treatment, but I'm not sure if it's warranted and the doctor knows that I don't necessarily have the experience to challenge that recommendation."

"I must confess...sometimes I'll need to find doctors by using a Google search or looking up a 'top 10' list somewhere. I know it's not the best approach, but I'm not always sure of the best approach. Sometimes I feel like they're the best advertisers, but not necessarily the best providers."

"To be honest, this is why I've been leaning toward the occupational medical centers. They claim to manage everything for FREE, all the employee's treatment(s) are done in one place, and it alleviates a great deal of work for me. I worry, though, because I know that the more treatments these facilities provide, the more they get paid...I'm not sure if they're all even needed or if they might be making the disabilities worse. With no checks and balances, how can I know whether they are prioritizing the patient's recovery or their income stream?"

"Another problem is that once our cases are closed, I have no idea if the treatment(s) were successful or not after paying so much for them. It's hard to get data, and since each case is unique, I don't know what could (or should) have been done differently, or whether the outcome was even successful given the circumstances."

TRUE CONFESSIONS ON WORKERS' COMPENSATION: Part Two

The Upper Management Executive: "I Know that Ultimately, the Buck Stops Here"

"Despite what anyone thinks, we're the ones who are primarily responsible for the financial results of this company. Even though we're expected to adhere to a number of other management metrics and requirements like case load and expense ratios, it all comes down to the bottom line."

"To run an effective business, we have to manage the numbers, maintain a fully trained staff, ensure productivity, remain compliant with reinsurance reports, and provide any other information that needs to be reported. That's a lot, and controlling expenses is key."

"Here in New Jersey, it's not 'business as usual'. This is a 'Bureau Rated' state, which means that the state dictates the rates that the insurer uses and provides an incentive over the 'file and use' states where the department reviews your book of business and then decides on your rates. Usually there is a lot of pressure on the insurance company to keep expenses down to ensure rates are approved...but not here."

"In 'Bureau States' such as New Jersey, there is much less pressure on the expense component, but more pressure on the combined ratio...management can spend whatever it wants to on expenses, as long as those expenses reduce the combined ratio. Doesn't always make sense, especially when it's part of your job to manage expenses responsibly."

"This is why managed care is so relevant in the state of New Jersey. Yes, managed care will add an expense. But when performed properly, managed care will ultimately reduce expenses many times in excess of the additional cost."

"So in New Jersey, the key for upper management is to avoid a less expensive "pretend-care" type of coverage for coverage that may cost more initially, but deliver real savings in the long run on business losses.
As the saying goes, don't be penny-wise and pound foolish!"

SECTION VI:

IMPLEMENTING THE PROPER TOOLS FOR OPTIMAL PROGRAM UTILIZATION

The most successful workers' compensation programs have a variety of components that, when implemented properly, help to ensure the well-being of both injured worker(s) returning to work, as well as the financial investment of the employer. Each individual component works seamlessly with the others to help maintain system integrity, ensure quality of care, employ double checks for accuracy, and protect the employer and injured worker as they safely return to work.

To ensure optimal utilization of your workers' compensation system and its benefits, the following tools should be in place:

Return to Work Program

Just as every employee is unique, the amount of recovery time that each injured employee may require to return to his/her full physical function can vary significantly. The employer and/or agent's ability to reintegrate the employee into the work environment on alternate duty plays an important role in the employee's recovery. It is vital that the employer and/or agent take extra care to protect the employee from re-injury during the recovery period. For this reason, a return to work program should be designed to ensure that the job functions assigned to the recovering employee fit within any restrictions outlined by the treating physician(s), and that these tasks/job duties are normally carried out by paid employees.

Independent Medical Examiner

An important component of a successful return to work program is an Independent Medical Examiner (IME), who has no allegiance or vested interest in the diagnosis. It is the IME's responsibility to provide a conclusion for the employee(s) diagnosis and treatment plan in cases where there are issues regarding the medical progress of the patient.

Case Manager

To streamline an injured worker's care and ensure the process is efficient for both patient and employer, a registered nurse case manager should be assigned to oversee each case. This individual is responsible for overseeing the complex medical management of each case, minimizing redundancies in care and testing, coordinating care administered by multiple specialists, ensuring prescribed therapies are appropriate, and ensuring the financial costs of the case are appropriate and reasonable.

Field Case Manager(s)

In some instances, injured employee(s) may require a Field Case Manager, a nurse who provides additional support on the path to recovery. This nurse case manager is available to attend medical appointments, make home visits, and in cases of hospitalization, provide bedside visits and coordinate care with the hospital case manager. In cases involving severe or catastrophic injuries, a field nurse case manager is imperative, as he/she will coordinate with the hospital case manager to initiate care and establish a communication stream among the adjuster, employer, providers, and employee.

Did You Know?

Coordinating an injured worker's transfer to centers of excellence within the provider network early in the course of treatment often makes a significant difference in the clinical outcome of an injury.

Network

There are a number of benefits for both injured employees and employer and/or agents in using a network-based system of provider care for workers' compensation. First, these situations provide for a more coordinated and familiar system of care, rather than a "patchwork" group of providers who are unfamiliar with one another and each other's way of practicing. In addition, a network-based system is comprised of providers who are familiar with workers' compensation, and the necessary procedures and protocols mandated by this unique situation. Network providers are accustomed to working in a teamwork-style approach with patients, nurse case managers, adjusters, and employer and/or agents to help the employee return to work in the safest and most efficient manner.

Second Opinion

In more complex or catastrophic cases, it is most beneficial for the employee and employer and/or agent to have an in-network consultant to provide an expert second opinion and monitor the progress of the injured employee(s). This consultant should be able to confirm that the patient is receiving the appropriate course of treatment(s) and in the correct manner. In those cases requiring surgery, this consultant can provide a second opinion confirmation for the intended procedure(s), and in some cases may take over the case moving forward. In all cases, it is important to ensure the consultant issuing a second opinion is a physician who works within your network and operates in an in-network facility or hospital to help coordinate and streamline patient care.

Functional Capacity Exam

A safe and comprehensive return-to-work program should include a Functional Capacity Exam (FCE), which is a series of standardized tests used to assess a worker's functional capacities. The goal of an FCE assessment is to compare the worker's current physical condition and abilities to those required functional demands in their job duties (e.g.: standing, bending, weight-bearing duties, etc.). As such, it is imperative to have a detailed listing of the worker's job description in order to mimic those duties during the FCE assessment.

A FORMAL JOB DESCRIPTION: MAKE SURE IT'S IN THE FILE!

It is the case manager's responsibility to secure a written copy of the injured employee's formal job description in the initial interview phase(s) of the case. It is a vital document used to ensure that, after recovery, the employee is fully able to return to the duties dictated by his/her position in the workplace.

Work Conditioning and Work Hardening

Another important component of any comprehensive return-to-work program is that of Work Conditioning and Work Hardening, which is a highly structured, goal-oriented, and individualized program designed to return the rehabilitated employee to work safely. Specifically, the program is a work-related treatment program designed to restore an individual's systemic, neuro-muscular, and cardiopulmonary function which consists of retraining the employee by recreating work simulation(s) of the actual job(s) the employee is expected to perform. The process is generally completed in two distinct phases:

- Work Conditioning: 3-hour training sessions, traditionally authorized in a 6-9 week series; and

- Work Hardening: Half or full-day sessions, often scheduled on a weekly basis.

As with the Functional Capacity Exam (FCE), a detailed listing of the patient's specific job duties is necessary to complete this program, because a critical aspect of Work Hardening is to perform a work simulation of the actual job the recovered patient is expected to perform. It is a highly individualized program -- each employee will be different, just as each approach in the frequency and the length of time for each treatment will vary. As such, the health care provider's input is critical in determining which discipline(s) will work best for each patient.

Fit for Duty Exam

The final program component in a return-to-work program should be a Fit for Duty Exam, which is performed to determine whether the employee has the ability to safely return to the job they left. This exam helps to protect both the employee and employer. As part of that exam, the provider must address the worker's functional capacities as they relate to their occupational duties. Therefore, it is essential that the employer provide a comprehensive and detailed job description for the worker, complete with an analysis of the functional/physical requirement(s) of each job function, so the provider can determine the employee's ability to return to work and fulfill his/her required duties.

SECTION VII:

FREQUENTLY ASKED QUESTIONS

1. **Are medical provider fees regulated and structured in New Jersey like they are in other states (i.e.: fees are based on a "usual and customary-based" schedule)?**

   No. New Jersey is one of the few states that does not have a set "fee schedule," and is also one of the few states where the employer (and/or agent) can direct care for the life of the workers' compensation claim.

2. **Are provider fees monitored by the state or should they be monitored by my individual workers' compensation insurance provider?**

   No. When providers do not belong to a network, most often repricing organizations will automatically reduce providers' billing and providers can dispute the amount. For this reason, New Jersey provides a separate track in its workers' compensation court devoted solely to billing disputes. For managed care organizations, however, providers have pre-existing agreements regarding rates. For more information, see "What are the implications of having no fee schedule" on page 10.

3. **How do I know if we are being overcharged for medical services?**

   If you are using a managed care organization, your providers will be operating under rates that have been pre-negotiated and discounted, and that are considered well within the scope of reasonable and customary charges. Providers that are not part of a managed care network can charge for services as they choose. In those instances, repricing organizations aim to detect any excess charges and pay what is "reasonable and customary." Providers can still dispute the discounted rates through the workers' compensation court.

4. **What should I do if I suspect fraud?**

   If you suspect fraudulent activity by a worker, an employer, a medical provider or an attorney with respect to a pending workers' compensation case, you should contact the New Jersey Division of Workers' Compensation Fraud Coordinator by email at ocsf@dol.state.nj.us or call (609) 292-2414. For information regarding all aspects of fraud, including uninsured employers, misrepresentation of payroll or classification and more, visit http://lwd.dol.state.nj.us/labor/wc/content/fraud.html.

5. **What is the best way to contain workers' compensation costs when there are a number of uncertainties?**

   One of the most effective ways for controlling workers' compensation costs for the long-term is to select a managed care organization that can provide a discount for being qualified as a WCMCO. Under these plans, employers have the benefits of premium discounts, a closely-monitored "care path," a broad provider network that is experienced in workers' compensation cases, and a professional team who shares the goals of employee recovery, safe return to work, and cost containment.

6. When does an out-of-state employer require workers' compensation insurance in New Jersey?

Out-of-state employers may need to obtain coverage if a contract of employment is entered into in New Jersey, or if the work is performed in the state. Learn more on page 11.

7. What are the requirements in order to qualify for a managed care premium discount?

In order to receive a discount of 5% or more on their insurance premium(s), employers should choose an insurer who offers a managed care organization that is certified and approved as a WCMCO by the Department of Banking and Insurance. Find out more in the "Quality Check" section on page 19.

8. Does a payment for an injured employee's emergency medical treatment mean I'll have to pay for the entire claim?

No. In New Jersey, the employer and/or agent has the right to designate the authorized treating physician(s). An injured worker may choose the treating physician ONLY in an emergency situation or if the employer inappropriately refuses to provide medical treatment. In case(s) of emergency, the employer should be notified as soon as possible. See "NOTE" section on page 8.

9. Is there any state-mandated reporting required?

Yes. The following two forms are now required:

First Report of Accident (FROI/IA-1), which replaces the L&I1, RM-2, WC-1 and WC-2 forms, must be filed within three weeks after learning of an accident, or obtaining knowledge of the occurrence of a compensable occupational disease. A copy of this report is sent to the employer.

Subsequent (Final) Report of Accident (SROI /SA/ IA-2), which replaces the WC-3, must be filed within 26 weeks after employee has recovered so as to be able to resume work or has reached maximum medical improvement. Information on this report is copied to the employee via a form called the Benefits Status Letter.

10. Many New Jersey networks claim to offer substantial discounts. How do I know which one to choose?

Most often, medical bills are processed through a national repricing service that "stacks" networks to ensure that the employer consistently receives discounted billings. The only way to properly access a network is to compare its results to the U&C standards. Some networks can often provide a false sense of savings because providers are aware that they are not receiving referrals and can therefore negotiate a fee that is high enough to avoid the appeal process. In short, they can set their rates knowing they will be offering a 50% discount, so they can be essentially doubled in anticipation of the reduction. For more details, see "Important Things to Know When Choosing a Network in New Jersey" on page 23.

SECTION VIII:

HELPFUL CONTACTS AND RESOURCES

Questions about New Jersey's Workers' Compensation Program:

New Jersey Department of Labor and Workforce Development
Division of Workers' Compensation
P.O. Box 381
Trenton, NJ 08625-0381
(609) 292-2515
Fax (609) 984-2515
Email: dwc@dol.state.nj.us
http://lwd.dol.state.nj.us/labor/wc/wc_index.html
Division of Workers' Compensation website: www.nj.gov/labor/wc

Questions about Workers' Compensation Insurance Rates, Obtaining Coverage, Premium Information and Rate Setting:

New Jersey Compensation Rating and Inspection Bureau (NJCRIB)
(an agency in the New Jersey Department of Banking and Insurance)
60 Park Place
Newark, NJ 07102
www.njcrib.com
(973) 622-6014
fax (973) 622-6110

Information on How Workers' Compensation Policy Rates are Established:

Worker's Compensation Reference Guide at: www.njcrib.com/ReferenceGuide/cribcnst.asp

Information regarding Managed Care Organizations and Discounts:

http://www.state.nj.us/dobi/division_insurance/managedcare/wcmco.htm#describewcmco

Information regarding self-insurance:

Department of Banking and Insurance
(609) 292-5350, ext. 50099
http://www.state.nj.us/dobi/index.html
or refer to N.J.S.A. 34:15-77 of the New Jersey Workers' Compensation Statute

Information about First MCO:

www.firstmco.com
marketing@firstmco.com

FIRST MCO

First Managed Care Option

First MCO was incorporated in 1979 and began working in the insurance industry to manage the utilization of care and costs associated with workers' compensation and auto claims.

In 1993, we became the first statewide licensed managed care organization in the state of New Jersey. We continue to work with insurance companies, self-insurers, third party administrators (TPAs), and insurance funds to provide comprehensive medical management and cost containment services for workers' compensation.

Our programs include proprietary mechanisms for monitoring patient care and enable us to reduce inefficiencies, optimize care plans, and improve financial management.

Our skilled medical team and professional staff will deliver valid case management, utilization management, bill review, and network access. At First MCO we promote positives outcomes that help control costs for every person and organization we serve. We do this by bringing together the technology, intelligence, and a human touch to the challenges of the workers' compensation marketplace.