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Notice of Rulemaking Hearing

Hearings will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, T.C.A. § 4-5-204. For questions and copies of the notice, contact the person listed below.

Agency/Board/Commission: Tennessee Department of Labor and Workforce Development
Division: Bureau of Workers' Compensation
Contact Person: Troy Haley
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Any individuals with disabilities who wish to participate in these proceedings (to review these filings) and may require aid to facilitate such participation should contact the following at least 10 days prior to the hearing:

ADA Contact: Troy Haley
Address: 220 French Landing Drive, 1-B, Nashville, TN 37243
Phone: 615-532-0179
Email: troy.haley@tn.gov

Hearing Location(s) (for additional locations, copy and paste table)

| | |
|----------------|-------------------------------|
| Address 1: | 220 French Landing Drive, 1-A |
| Address 2: | Tennessee Room |
| City: | Nashville |
| Zip: | 37243 |
| Hearing Date : | 08/31/2016 |
| Hearing Time: | 2:00 p.m. CST/CDT |

Additional Hearing Information:

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Revision Type (check all that apply):

- Amendment
 New
 Repeal

Rule(s) (ALL chapters and rules contained in filing must be listed. If needed, copy and paste additional tables to accommodate more than one chapter. Please enter only **ONE** Rule Number/Rule Title per row.)

| Chapter Number | Chapter Title |
|----------------|---|
| 0800-02-06 | General Rules of the Workers' Compensation Program – Utilization Review |
| Rule Number | Rule Title |
| 0800-02-06-.01 | Definitions |
| 0800-02-06-.02 | Utilization Review System |
| 0800-02-06-.03 | Utilization Review Requirements |
| 0800-02-06-.04 | Contents of Utilization Review Report |
| 0800-02-06-.05 | Mandatory Utilization Review |
| 0800-02-06-.06 | Time Requirements |
| 0800-02-06-.07 | Appeals of Utilization Review Decisions |
| 0800-02-06-.08 | Utilization Review Forms |
| 0800-02-06-.09 | Subcontractors |
| 0800-02-06-.10 | Sanctions and Civil Penalties |
| 0800-02-06-.11 | Issuance and Appeal of Sanctions and Civil Penalty Assessments |

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to <http://state.tn.us/sos/rules/1360/1360.htm>)

0800-02-06-.01 DEFINITIONS.

The following definitions are for the purpose of these Utilization Review Rules, Chapter 0800-02-06:

- ~~(1)~~ "Act" means the Tennessee Workers' Compensation Act, T.C.A. §§ 50-6-101, et seq., as amended.
- ~~(2)~~(1) "Administrator" means the chief administrative officer of the Bureau of Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development, or the Administrator's designee.
- ~~(3)~~(2) "Advisory Medical Practitioner" means an actively Tennessee-licensed practitioner, who is board certified, who is in good standing, who is in the same or similar general specialty as the recommending authorized treating physician, and who makes utilization review determinations for the utilization review organization agent or the Bureau Department.
- ~~(4)~~(3) "Authorized Treating Physician" means the practitioner chosen from the panel required by T.C.A. § 50-6-204 or a practitioner referred to by the practitioner chosen from the panel required by T.C.A. § 50-6-204, as appropriate. Authorized Treating Physician shall also include any other medical professional recognized and authorized by the employer or designated by the Bureau Division to treat any injured employee for a work-related injury or condition.
- ~~(4)~~ "Bureau" means the Tennessee Bureau of Workers' Compensation.
- (5) "Business day" means any day upon which the Tennessee Bureau of Workers' Compensation Division is open for business.
- ~~(6)~~ "Commissioner" means the Commissioner of the Tennessee Department of Labor and Workforce Development, the Commissioner's Designee, or an agency member appointed by the Commissioner.
- (6) ~~(7)~~ "Contractor" means an independent utilization review organization not owned by or affiliated with any carrier authorized to write workers' compensation insurance in the state of Tennessee with which the Administrator has contracted to provide utilization review, including peer review, for the Division Bureau, as referred to in T.C.A. § 50-6-124.
- ~~(8)~~ "Department" means the Tennessee Department of Labor and Workforce Development. "Bureau"
- ~~(9)~~ "Division" means the Bureau of Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development.
- (7) ~~(10)~~ "Employee" means an employee as defined in T.C.A. § 50-6-102, but also includes the employee's legally authorized representative or legal counsel.

- (8) ~~(11)~~ "Employer" means an employer as defined in T.C.A. § 50-6-102, but also includes an employer's insurer, third party administrator, self-insured employers, self-insured pools and trusts, as well as the employer's legally authorized representative or legal counsel, as applicable.
- (9) ~~(12)~~ "Health care provider" includes, but is not limited to, the following: licensed individual, chiropractor, dentist, occupational therapist, physical therapist, physician, surgeon, optometrist, podiatrist, pharmacist, group of practitioners, hospital, free standing surgical outpatient facility, health maintenance organization, industrial or other clinic, occupational healthcare center, home health agency, visiting nursing association, laboratory, medical supply company, community mental health center, and any other facility or entity providing treatment or health care services for a work-related injury within the scope of their license.
- (10) ~~(13)~~ "Inpatient services" means services rendered to a person who is formally admitted to a hospital and whose length of stay exceeds twenty-three (23) hours is in accordance with the Medicare rules for "inpatient status."
- (11) ~~(14)~~ "Medical Director" means the Medical Director of the Bureau ~~Division~~ appointed by the Administrator pursuant to T.C.A. § 50-6-126, or the Medical Director's designee chosen by the Administrator to act on behalf of the Medical Director.
- (12) ~~(15)~~ "Medical necessity" means ~~health care services that a practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are in accordance with generally accepted standards of medical practice.~~ "Medically necessary" or "medical necessity" means healthcare services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
- (a) In accordance with generally accepted standards of medical practice;
- (b) Clinically appropriate, in terms of type, frequency, extent, site and duration; and considered effective for the patient's illness, injury or disease; and
- (c) Not primarily for the convenience of the patient, physician, or other healthcare provider; and
- (d) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease;
- (13) ~~(16)~~ "Outpatient services" means a service provided by the following, but not limited to, types of facilities: physicians' offices and clinics, hospital emergency rooms, hospital outpatient facilities, community mental health centers, outpatient psychiatric hospitals, outpatient psychiatric units, and freestanding surgical outpatient facilities also known as ambulatory surgical centers. Outpatient services may also include hospital admissions that do not qualify as "inpatient admissions" under Medicare regulations appropriate for the date of discharge for a patient whose length of stay does not exceed twenty-three (23) hours.
- (14) ~~(17)~~ "Parties" means the employee, authorized treating physician, ~~and~~ employer, and their legal representatives as those terms are defined herein.
- ~~(15)~~ ~~(18)~~ "Practitioner" means a person currently licensed in good standing to practice as a doctor of medicine, doctor of osteopathy, doctor of chiropractic, or doctor of dental medicine or dental surgery.
- ~~(15)~~ ~~(16)~~ "Preauthorization" for workers' compensation claims means that the employer, prospectively or concurrently, authorizes the payment of medical benefits. Preauthorization

for workers' compensation claims does not mean that the employer accepts the claim or has made a final determination on the compensability of the claim. Preauthorization for workers' compensation claims does not include utilization review.

~~(16)~~(17) ~~(19)~~ "Recommended treatment" means the recommendation of the authorized treating physician to perform or refer treatments, procedures, surgeries, including medications but not limited to Schedule II, III, or IV controlled substances after 90 days, and/or admissions in either an inpatient or outpatient setting. Recommended treatment shall also mean emergency treatments, procedures, surgeries, and/or admissions when retrospective review is performed.

~~(18)~~ ~~(20)~~ "Records" means medical records and reports regarding an employee's claim for workers' compensation benefits. Records include electronic imaging of such documents.

(19) "Treatment Guidelines" means statements that include recommendations intended to optimize patient care that are informed by a systematic review of the evidence and an assessment of the benefit and harms of alternative care options. The statements and other documents that accompany the guidelines are those that are adopted by the Bureau –Division–effective on January 1, 2016 and updated as new information warrants, periodically.

~~(21)~~(20) "Utilization review" means evaluation of the necessity, appropriateness, efficiency and quality of medical services, including the prescribing of one (1) or more Schedule II, III or IV controlled substances for pain management for a period of time exceeding ninety (90) days from the initial prescription of such controlled substances, provided to an injured or disabled employee based upon medically accepted standards and an objective evaluation of the medical care services provided; provided, that "utilization review" does not include the establishment of approved payment levels, a review of medical charges or fees, or an initial evaluation of an injured or disabled employee by a physician specializing in pain management. "Utilization review," also known as "Utilization management," does not include the evaluation or determination of causation or the compensability of a claim. For workers' compensation claims, "utilization review" is not a component of preauthorization evaluating the quality and appropriateness of health care or health care services in workers' compensation cases pursuant to the timeframes, procedures, and requirements of this Chapter, 0800-02-06, and as defined in T.C.A. § 50-6-102. The employer shall be responsible for all costs associated with utilization review and shall in no event obligate the employee, health care provider or Bureau Department to pay for such services.

(Rule

~~(213)~~ ~~(22)~~ "Utilization review agent/organization" means an individual or entity authorized to do business and provide utilization review services in Tennessee, ~~having~~ All Utilization review agents/organizations are required to be certified toby the Commissioner of Commerce and Insurance pursuant to T.C.A. §§ 56-6-701, et seq., and registered with the Bureau Division, complying with the accreditation requirement in T.C.A. § 50-6-124(a).

Authority: T.C.A. §§ 50-6-102, 50-6-124, 50-6-126, 50-6-233, ~~and Public Chapters 282 & 289 (2013).~~

Administrative History: Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed May 13, 1997; effective July 27, 1997. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009. Amendment filed December 26, 2013; effective March 26, 2014.

0800-02-06-.02 UTILIZATION REVIEW SYSTEM.

- (1) This Chapter shall apply to all recommended treatments as defined above for work-related injuries or conditions whenever the recommendation is made after this Chapter, as amended, becomes effective.
- (2) Employers shall establish and maintain a system of utilization review. An employer may choose to provide utilization review services itself, through its insurer or through a third party administrator. Whenever utilization review is conducted, whether mandatory under this Chapter, 0800-02-06, or not, such utilization review shall be conducted in complete conformity with this Chapter. Failure to comply with this Chapter in any way may subject the

employer and utilization review organization agent to sanctions and/or civil penalties as set forth in Rule 0800-02-06-.10. The Administrator, the Medical Director or the Court of Workers' Compensation Claims ~~a workers' compensation specialist~~ may determine whether a utilization review was conducted in conformity with this Chapter and may determine that a utilization review is void.

- (3) The Administrator may provide or contract for certain utilization review services with a Contractor. The Contractor may provide any service allowed by T.C.A. § 50-6-124, including, but not limited to, reviewing utilization review services and providing peer review. The parties shall cooperate and provide any necessary medical information to the Contractor when requested, which shall not constitute a waiver of any applicable privilege or confidentiality.
- (4) Any organization conducting utilization review for workers' compensation cases pursuant to this Chapter shall provide to the Administrator copies of any information provided to the Commissioner of Commerce and Insurance pursuant to T.C.A. § 56-6-704. Any organization conducting utilization review for workers' compensation cases must also register with the Division Bureau on a form prescribed by the Administrator. Failure to certify to the Commissioner of Commerce and Insurance and be registered with the Bureau Division prior to performing utilization review services may result in sanctions and/or civil penalties pursuant to Rule 0800-02-06-.10 of this Chapter.
- (5) Subject to any applicable requirements of law concerning confidentiality of records, a utilization review organization agent shall provide the Division Bureau, including the Medical Director, with any appropriate utilization review records or permit the Division Bureau to inspect, review, or copy such records in a reasonable manner. The Division Bureau will maintain any required confidentiality of any personally identifying information concerning employees claiming workers' compensation benefits. Provision of these records pursuant to this rule shall not constitute a waiver of any applicable privilege or confidentiality.
- (6) In no event shall an individual concurrently perform case management services, as set forth in Chapter 0800-02-07, and utilization review with regard to a single claim of work-related injury.
- (7) Billing and payment for any medical services provided in conjunction with this Chapter shall be subject, as applicable, to the Division Bureau's Medical Cost Containment Program, Medical Fee Schedule, or In-Patient Hospital Fee Schedule rules contained in Chapters 0800-02-17, 0800-02-18, and 0800-02-19, respectively.

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126, 50-6-233, ~~and Public Chapters 282 & 289 (2013)~~. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed May 13, 1997; effective July 27, 1997. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009. Amendment filed December 26, 2013; effective March 26, 2014.

0800-02-06-.03 UTILIZATION REVIEW REQUIREMENTS.

- (1) In any case in which utilization review is undertaken, the utilization review organization agent shall make an objective evaluation of the recommended treatment as it relates to the employee's condition and render a determination concerning the medical necessity of the recommended treatment. A utilization review agent may contact the authorized treating physician regarding the recommended treatment pursuant to applicable law; provided that such contact shall not constitute a waiver of any other applicable privilege or confidentiality.
- (2) Upon initiation of utilization review, the authorized treating physician shall submit all necessary information to the utilization review organization agent and shall certify that the information is a complete copy of the health care provider's records and reports that are necessary for utilization review. The authorized treating physician shall also include the reason(s) for the necessity of the recommended treatment in such records and reports. The employer, or other payer, shall reimburse the authorized treating physician

for the costs of copying and transmitting such records; provided that the costs do not exceed the amounts prescribed by T.C.A. § 50-6-204. If a dispute arises as to the necessity of information, then the parties shall proceed as set forth in Rule 0800-02-06-.06(5).

- (3) Upon receipt of all necessary information, the initial utilization review decision may be determined by a licensed registered nurse whenever the recommended treatment is being approved. For all denials, the utilization review decision shall be determined by an advisory medical practitioner and communicated to the parties in a written utilization review report.
- (4) Any procedure or treatment, including medications, which follow the treatment guidelines approved by the Bureau is not subject to utilization review. See T.C.A. §50-6-124.

Authority: T.C.A. §§ 50-6-102, 50-6-124, 50-6-126, and 50-6-233. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009.

0800-02-06-.04 CONTENTS OF UTILIZATION REVIEW REPORT.

- (1) The utilization review organizationagent shall communicate its determination to the parties within the timeframe established in Rule 0800-02-06-.06.
- (2) Any modification in the recommended treatment request, including medications shall be considered to be a denial of the entirety of the treatment for the purposes of utilization review reports, appeals and determinations.
- (1)(3) If the utilization review determination is a denial of a recommended treatment, then the utilization review agentorganization shall submit a written utilization review report in conformity with the requirements of subsection (42) of this Rule. If the utilization review determination is an approval of a recommended treatment, then the utilization review organizationagent shall submit written documentation of the determination; provided that the written documentation is not required to be a utilization review report in conformity with the requirements of subsection (42) of this Rule. A utilization review report and other written documentation may be communicated through electronic means when available and appropriate.
- (2)(4) The utilization review report shall adhere to the following requirements:
 - (a) The utilization review organizationagent shall only consider only the medical necessity, appropriateness, efficiency, and quality of the recommended treatment for the employee's condition. The consideration under quality may include factors such as timeliness, effectiveness, efficacy, conformity to the Bureau's adopted Treatment Guidelines, and any other evidence based treatment guidelines (including the comments and observations) approved by the Administrator. Treatment recommendations shall not be denied if they follow the Bureau's adopted Treatment Guidelines.
 - (b) Whenever a utilization review organizationagent determines that the recommended treatment will be denied, the utilization review report must contain specific and detailed reasons for the denial, a listing of all the documents used to make the determination, and a record of any other communication between the advisory medical practitioner and the requesting provider.
 - (c) The utilization review organization agent shall also include the name, address, phone number and qualifications of the advisory medical practitioner making a denial determination.
 - (d) All utilization review reports that deny or modify any portion of a recommended treatment, including medications, shall include an appeal form prescribed by the DivisionBureau. The utilization review organizationagent shall

transmit a copy of the utilization review report and appeal form to the authorized treating physician, employee, and employer. Upon request, the utilization review ~~agent~~organization shall transmit any utilization review report to the ~~Bureau~~Division. Failure to include the appeal form in the utilization review report and transmit such to all parties may result in sanctions and/or civil penalties pursuant to Rule 0800-02-06-.10 of this Chapter.

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126, and 50-6-233. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed May 13, 1997; effective July 27, 1997. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009.

0800-02-06-.05 MANDATORY UTILIZATION REVIEW.

- (1) The parties are required to participate in utilization review under this Chapter whenever a dispute arises as to the medical necessity of a recommended treatment.
- (2) Utilization review is required to be performed pursuant to the requirements of this Chapter whenever it is mandated by T.C.A. § 50-6-124 or the ~~Bureau~~Division's Medical Cost Containment Program, Medical Fee Schedule, or In-Patient Hospital Fee Schedule rules contained in Chapters 0800-02-17, 0800-02-18, and 0800-02-19, respectively.

Authority: T.C.A. §§ 50-6-102, 50-6-124, 50-6-126, and 50-6-233. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009.

0800-02-06-.06 TIME REQUIREMENTS.

- (1) If a recommended treatment requires utilization review, then an employer shall submit the case to its utilization review ~~agent~~organization within three (3) business days of the authorized treating physician's notification of the recommended treatment, subject to subsection (5) of this Rule. The authorized treating physician's notification of the recommended treatment to the employer shall, at a minimum, be in a form that confirms transmission by showing the time and date of receipt (e.g., facsimile). The employer shall notify all parties upon submitting the case to its utilization review ~~organization agent~~agent, and shall also notify ~~the bureau any workers' compensation specialist assigned to the claim~~. If the employer fails to comply with this subsection, then the employer may be subject to sanctions and/or civil penalties pursuant to Rule 0800-02-06-.10 of this Chapter.
- (2) The utilization review ~~organization agent~~ shall render the determination and communicate the determination in writing to the authorized treating physician, employee and employer within seven (7) business days of receipt of the case from the employer, subject to subsection (5) of this Rule. If a denial, the utilization review report shall list all records and supplemental material reviewed by the utilization review ~~organization agent~~agent. Upon request, the authorized treating physician or employee may obtain copies of any such records and supplemental material reviewed by the utilization review ~~organization agent~~agent. The utilization review report shall also include an appeal form prescribed by the ~~Bureau~~Division on which the utilization review ~~organization agent~~agent shall identify the state file number associated with the claim for which treatment is being recommended, if any, and shall identify the utilization review ~~organization agent~~agent's certification number issued by the ~~Bureau~~Division. If the utilization review ~~organization agent~~agent fails to comply with this subsection, then the utilization review ~~organization agent~~agent may be subject to sanctions and/or civil penalties pursuant to Rule 0800-02-06-.10 of this Chapter.
- (3) ~~If a denial of the recommended treatment is appealed to the Bureau, then the employer as defined in Rule 0800-02-06-.01(8) utilization review agent shall send a copy of the utilization review report and all records reviewed by the utilization review organization agent to the Bureau upon request within five (5) business days of a the request from the Bureau.-~~
- (4) An approval of a recommended treatment by the employer's utilization review

organizationagent shall be final and binding on the parties for administrative purposes.

- (5) When there is a dispute over a request for information, the following timeframes shall apply:
- (a) If the employer or utilization review organizationagent does not possess all necessary information in order to evaluate dispute—the recommended treatment and or render the utilization review determination, then it shall immediately make a written request for such information to the authorized treating physician, who shall comply with the written request within five business days of receipt of the written request. The time requirements in subsections (1)-(2) of this Rule shall be tolled until the employer or utilization review organizationagent receives the necessary information or until the timeframe set forth in the preceding sentence expires, whichever occurs first.
 - (b) Denials for inadequate information may be appealed pursuant to Rule 0800-02-06-.07, at which time the authorized treating physician shall submit all information deemed to be necessary by the BureauDivision. If the BureauDivision finds that the employer's or utilization review organizationagent's request did not pertain to necessary information, then the employer or utilization review organization agent may be subject to sanctions and/or civil penalties as set forth in Rule 0800-02-06-.10, at the discretion of the Administrator. In addition, if an authorized treating physician fails to cooperate and timely furnish all necessary information, records and documentation to an employer or utilization review organizationagent, then the authorized treating physician may be subject to sanctions and/or civil penalties as set forth in Rule 0800-02-06-.10, at the discretion of the Administrator.
- (6) Employer's obligations upon receipt of utilization review determination:
- (a) Within three (3) business days of receiving a utilization review determination that denies the recommended treatment, the employer as defined in Rule 0800-02-06-.02(8) shall give written notification to the employee and authorized treating physician as to whether the employer will authorize any of the recommended treatments that were denied by the utilization review organizationagent and what, if any, conditions shall apply to such authorization.
 - (b) Within three (3) business days of receiving a utilization review determination that is either an approval or denial, the employer as defined in Rule 0800-02-06-.01(8) shall forward such determination to the bureauany workers' compensation specialist assigned to the claim. The employer shall also forward the notification described in subsection (6)(a) above, if applicable.
 - (a) .
 - (b) (a) The utilization review decision to deny a recommended treatment shall remain effective for a maximum of 6 months from the date of the decision without further action by the employer as defined in Rule 0800-02-06-.01(8) if the request is for the same treatment, unless there is a material change documented by the treating physician that supports a new review or other pertinent information that was not used by the utilization review organization in making the initial decision. This provision also applies to medication denials, or modifications.
 - (c) (b) This same 6-month provision applies to the determinations, including medications upheld by the Medical Director on appeal.

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126, 50-6-233, ~~and Public Chapters 282 & 289 (2013)~~. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed March 15, 1995; effective July 28, 1995. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009. Amendment filed December 26, 2013; effective March 26, 2014.

0800-02-06-.07 APPEALS OF UTILIZATION REVIEW DECISIONS.

- (1) Every denial of a recommended treatment shall be accompanied by a form prescribed by the

BureauDivision that informs the employee and authorized treating physician how to request an appeal with the BureauDivision. The employee or authorized treating physician shall have thirty (30) calendar days from receipt of a denial by an employer as defined in Rule 0800-02-06-.01(8) to request an appeal with the BureauDivision. The form and accompanying instructions provided shall be the current form and instructions adopted by the Bureau and posted on the Bureau's website.

- (2) Upon receipt of an appeal request by an employee or authorized treating physician:
- (a) The BureauDivision or its designated contractor shall conduct the utilization review appeal. The BureauDivision or its designated contractor may contact the authorized treating physician for the peer review purpose s-of obtaining any necessary missing information. The BureauDivision or its designated contractor shall determine the medical necessity of the recommended treatment as soon as practicable after receipt of all necessary information. The BureauDivision or its designated contractor shall then transmit such determination to the authorized treating physician, employee, and employer. The determination of the BureauDivision or its designated contractor is final for administrative purposes, subject to the provisions of subsections (3)-(5) of this Rule.
 - (b) If any information necessary for the determination of the appeal is not within the possession of the BureauDivision, then any party not providingwithholding such information may be subject to sanctions and/or civil penalties as set forth in Rule 0800-02-06-.10, at the discretion of the Administrator.
 - (c) The BureauDivision shall charge fees, as posted on its website, pursuant to Public Chapter 289 (2013) and T.C.A. §50-6-204(j) for each utilization review appeal that it completes. The fee shall be paid by the employer within thirty (30) calendar days of the Bureau's completion of the appeal. Failure to comply with this requirement may result in a civil penalty of not less than \$50 nor greater than \$5000 per violation. If there is a pattern of violations, the Administrator may consider suspension of participation in the Bureau's utilization review program. If the fee and/or penalty remain unpaid for a further 30 days, the Administrator may impose further civil penalties or sanctions, or request that the Department of Commerce and Insurance apply penalties/sanctions in accordance with their policies. The appeal of any fee or civil penalty assessed pursuant to this section shall be made in accordance with the Uniform Administrative Procedures Act, T.C.A. §§ 4-5-101, et seq., and the most current procedural rules of Chapter 0800-02-13, as may be amended periodically in the future, which are incorporated as if set forth fully herein.
 - (a) —
- (3) If the determination of the BureauDivision is an approval of part or all of the recommended treatment, then the Medical Director shall issue a determination that specifies the treatment(s) that is/are medically necessary. ~~a workers' compensation specialist shall issue an order for medical benefits.~~ The penalty provisions of T.C.A. §§ 50-6-238(d) and 50-6-118 shall apply to orders these determinations issued pursuant to this subsection (3).
- (4) For dates of injury on or after July 1, 2014, the decision of the Medical Director is final for administrative purposes. Within seven (7) calendar days of the receipt of the determination letter from the Medical Director, referenced in subsection (3) above, the insurance carrier is required to inform the provider that the procedure and /or treatment has been approved and request that the procedure or treatment be scheduled. The penalties under this subsection are those set forth in T.C.A §50-6-118.
- (5) A determination of denial is effective for a maximum period of 6 months from the date of the determination as set forth in rule 0800-02-06-.06(7).
- (6) ~~(4)If the~~ If a party disagrees with a determination of the BureauDivision is a denial of for the recommended treatment, then the parties may file a Petition for Benefits Determination (PBD) with the Court Of Workers' Compensation Claims. Request for Benefit Review Conference or may request a waiver of the benefit review conference

requirement, as applicable, within 30 days of receipt of the determination.

- (7) ~~(5)~~ Notwithstanding any other provision to the contrary, if the parties agree on a recommended treatment after the employer's utilization review ~~organization agent~~ has denied such, then the parties may, by joint agreement, override the determination of the employer's utilization review ~~organization agent or the Bureau~~ and approve the recommended treatment. Such approval by agreement shall terminate any appeal to the ~~Bureau Division~~ and no fee shall be required of the employer for any such appeal that has yet to be determined by the ~~Bureau Division~~.

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126, 50-6-204, 50-6-233, 50-6-238, ~~and Public Chapters 282 & 289 (2013)~~. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed March 15, 1995; effective July 28, 1995. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009. Amendment filed December 26, 2013; effective March 26, 2014.

0800-02-06-.08 UTILIZATION REVIEW FORMS.

- (1) All utilization review ~~organizations agents~~ must file the Utilization Review Notification form (Form C-35) ~~electronically within 3 (three) business days immediately~~ upon initiation of utilization review services on an employee's workers' compensation claim. ~~Only one form should be filed for each date of a utilization review referral even if more than one treatment is reviewed on that same date. Only one form is necessary for each claim.~~
- (2) All utilization review ~~organizations agents~~ must file the Utilization Review Closure form (Form C-36/C-37) ~~electronically for each C-35 filed within three(3) business days immediately~~ following the conclusion of utilization review services on an employee's workers' compensation claim. ~~Only one form is necessary for each claim.~~
- (3) ~~All~~ utilization review ~~organizations agents~~ must file an annual report ~~with the Medical Director of the Bureau on a form prescribed by the Division and accessible through the Division's website.~~

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126, and 50-6-233. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009.

0800-02-06-.09 SUBCONTRACTORS.

- (1) A utilization review ~~organization agent~~ shall be responsible for any advisory medical practitioner(s), ~~and~~ registered nurse(s), ~~or other utilization review organization(s)~~ with whom the utilization review ~~organization agent~~ subcontracts to perform utilization reviews. If a subcontractor performs a utilization review in accordance with the requirements of this Chapter, then the utilization review shall be treated as if performed by the contracting utilization review ~~organization agent~~. A utilization review ~~organization agent~~ shall be liable for all sanctions and/or civil penalties contained in this Chapter whenever its subcontractor violates any provision contained herein.
- ~~(2) A utilization review organization agent may only subcontract with an advisory medical practitioner as defined in Rule 0800-02-06-.01(3) or registered nurse. All other subcontracting for utilization review services is prohibited and will result in the invalidity of such utilization review determination.~~

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126, and 50-6-233. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009.

0800-02-06-.10 SANCTIONS AND CIVIL PENALTIES.

- (1) ~~Failure~~ by an employer, insurer, third party administrator, or utilization review ~~organization agent~~ to comply with any requirement in this Chapter, 0800-02-06, including

but not limited to applying utilization review when required, proper inclusion of the forms with notification of a denial, and complying with the timeframes and registration for utilization review, shall subject such party to a penalty of not less than fifty dollars (\$50.00) nor more than five thousand dollars (\$5,000.00) one hundred dollars (\$100.00) nor more than one thousand dollars (\$1,000.00) per violation at the discretion of the Administrator. The BureauDivision may also institute a temporary or permanent suspension of the right to perform utilization review services for workers' compensation claims, if the utilization review organization agent has established a pattern of violations. This includes licensing and specialty requirements for an Advisory Medical Practitioner as defined in 0800-02-06-.01(3) and timeframes for the provision of medical records and other required documentation in 0800-02-06-.06(5)(b).

~~(1)(2)A health care provider is subject to the penalties enumerated in T.C.A. § 50-6-124(e) as if set forth fully herein.~~

- (2) ~~(3)~~The penalty for failure to timely file the Form C-35 or Form C-36/C-37 in accordance with Rule 0800-02-06-.08 is twenty-five dollars (\$25) for each fifteen (15) calendar days past the initiation deadlines listed above or conclusion of utilization review services, as applicable, per violation. The penalty for failure to file the annual report in accordance with Rule 0800-02-06-.08 is twenty-five dollars (\$25) for each fifteen (15) calendar days past the final date for filing the annual report.

Authority: T.C.A. §§ 4-5-314, 50-6-102, 50-6-118, 50-6-124, 50-6-126, 50-6-233, ~~and Public Chapters 282 & 289 (2013)~~. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009. Amendment filed December 26, 2013; effective March 26, 2014.

0800-02-06-.11 ISSUANCE AND APPEAL OF SANCTIONS AND CIVIL PENALTY ASSESSMENTS.

(1) An agency decision assessing sanctions and/or civil penalties shall be communicated to the party to whom the decision is issued, and the party to whom it is issued shall have fifteen (15) calendar days from the date of issuance to either appeal the decision pursuant to the procedures provided for under the Uniform Administrative Procedures Act, T.C.A. §§ 4-5-101, et seq., or to pay the assessed penalties to the ~~Bureau Department~~ or otherwise comply with the decision.

~~(1)(2)~~

(2) In order for a party to appeal an agency decision assessing sanctions and/or civil penalties, the party must file a petition with the ~~Commissioner~~ Administrator within fifteen (15) calendar days of the issuance of the decision. This petition shall be considered a request for a contested case hearing within the ~~Department~~ Bureau pursuant to the Uniform Administrative Procedures Act, T.C.A.

— §§ 4-5-101, et seq., and the procedural rules of Chapter 0800-02-13, as amended periodically in the future, are incorporated as if set forth fully herein. The ~~Bureau Department~~ is authorized to conduct the hearing pursuant to T.C.A. § 50-6-118.

(3) If the agency decision assessing sanctions and/or civil penalties is not appealed within fifteen (15) calendar days of its issuance, the decision shall become a final order of the ~~Department Bureau and is~~ not subject to further review.

Authority: T.C.A. §§ 4-5-314, 50-6-102, 50-6-118, 50-6-124, 50-6-126, and 50-6-233. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009.

I certify that the information included in this filing is an accurate and complete representation of the intent and scope of rulemaking proposed by the agency.

Date: _____

Signature: _____

Name of Officer: _____

Title of Officer: _____

Subscribed and sworn to before me on: _____

Notary Public Signature: _____

My commission expires on: _____

Department of State Use Only

Filed with the Department of State on: _____

Tre Hargett
Secretary of State