RULES
OF
THE TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
BUREAU OF WORKERS' COMPENSATION

CHAPTER 0800-02-06
GENERAL RULES OF THE WORKERS' COMPENSATION PROGRAM
UTILIZATION REVIEW

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0800-02-06-.01 DEFINITIONS.

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

(1) "Administrator" means the chief administrative officer of the Bureau of Workers' Compensation of the Tennessee Department of Labor and Workforce Development, or the Administrator's designee.

(2) "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 to treat any injured employee for a work-related injury or condition.

(3) "Bureau" means the Tennessee Bureau of Workers' Compensation.

(4) "Business day" means any day upon which the Tennessee Bureau of Workers' Compensation is open for business.

(5) "Claims adjuster" or "adjuster" means a representative of an adjusting entity who investigates workers' compensation claims for the purposes of making compensability determinations, files or causes claims forms to be filed with the Bureau, commences benefits, and/or makes settlement recommendations based on the insured's liability on behalf of a self-insured employer, trade, or professional association, third party administrator, and/or insurance company or carrier.

(6) "Compliance Contact" means the email address for the unit or individual, other than the claim's adjuster, responsible for responding to matters regarding the claim on behalf of the employer's insurer, self-insured employer, third party administrator, or self-insured pool and trust.

(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 Bureau, as referred to in T.C.A. § 50-6-124.

(Rule 0800-02-06-.01, continued)

(8) "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.

(9) "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.

(10) "Health care provider" includes, but is not limited to, the following: licensed individual, chiropractor, dentist, occupational therapist, physical therapist, physician, doctor of osteopathy, 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.

(11) "Inpatient services" means services rendered to a person who is formally admitted to a hospital and whose length of stay is in accordance with the Medicare rules for "inpatient status."

(12) "Medical Director" means the Medical Director of the Bureau 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.

(13) "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, including Treatment Guidelines as defined in Rule 0800-02-06-.01(19);

(b) Clinically appropriate, in terms of type, frequency, extent, site and duration; and considered effective for the patient's illness, injury or disease;

(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.

(14) "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.

(15) "Parties" means the employee, authorized treating physician, employer, and their legal representatives as those terms are defined herein.

(16) "Peer-to-Peer" means the communication between the authorized treating physician and the utilization review physician regarding the utilization review of treatment recommended by the

(Rule 0800-02-06-.01, continued)

authorized treating physician. "Peer" as used in these rules may include the authorized treating physician and the utilization review physician.

(17) "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.

(18) "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 shall not mean utilization review as defined in these rules.

(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.

(20) "Reconsideration" means a request from the authorized treating physician to the utilization review organization or the employer to review the initial denial of treatment recommended by the authorized treating physician.

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

(22) "Same or similar specialty" means a medical doctor, doctor of osteopathy, chiropractor or dentist (M.D., D.O., D.C., D.D.S. or D.M.D.) trained in the same or similar specialty of medicine that typically manages the medical condition, procedure, or treatment under discussion and thus is able to understand the rationale and current medical evidence for the request. The determination of same or similar specialty shall be made by the Administrator.

(23) "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 effective on January 1, 2016, and periodically updated as new information warrants.

(24) "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. "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" does not include preauthorization as defined in these rules. 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 to pay for such services.

(25) "Utilization review agent/organization" (URO) means an individual or entity authorized to do business and provide utilization review services in Tennessee. All utilization review

(Rule 0800-02-06-.01, continued)

agents/organizations are required to be certified by the Commissioner of Commerce and Insurance pursuant to T.C.A. §§ 56-6-701, et seq., and registered with the Bureau, complying with the accreditation requirement in T.C.A. § 50-6-124(a).

(26) "Utilization review physician" means an actively Tennessee-licensed doctor of medicine, doctor of osteopathy, doctor of chiropractic, or doctor of dental medicine or dental surgery, who is board certified, who is in good standing, who is in the same or similar specialty as the recommending authorized treating physician, and who makes utilization review determinations for the utilization review organization.

Authority: *T.C.A. §§ 50-6-102, 50-6-124, 50-6-126, and 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. Amendments filed October 31, 2016; effective January 29, 2017. Amendments filed July 1, 2022; effective September 29, 2022.*

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 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, 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 Bureau on a form prescribed by the Administrator. Failure to certify to the Commissioner of Commerce and Insurance and be registered with the Bureau 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 shall provide the Bureau, including the Medical Director, with any appropriate utilization review records or permit the Bureau to inspect, review, or copy such records in a reasonable manner. The 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.

(Rule 0800-02-06-.02, continued)

(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 a work-related injury.

(7) Billing and payment for any medical services provided in conjunction with this Chapter shall be subject, as applicable, to the 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, and 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. Amendments filed October 31, 2016; effective January 29, 2017.*

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

(1) In any case in which utilization review is undertaken, the utilization review organization 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 shall contact the authorized treating physician regarding the recommended treatment pursuant to applicable law and Rule 0800-02-06-.06; 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 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 completeness or 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 a utilization review physician and communicated to the parties in a written utilization review report.

(4) Any treatment that explicitly follows the Treatment Guidelines, including medications, adopted by the administrator or is reasonably derived therefrom, including allowances for specific adjustments to treatment, shall have a presumption of medical necessity for utilization review purposes. This presumption shall be rebuttable only by clear and convincing evidence that the treatment erroneously applies the guidelines or that the treatment presents an unwarranted risk to the injured worker.

(5) If a question arises in a Utilization Review denial, as to whether a recommended treatment follows the guidelines adopted by the administrator or is reasonably derived therefrom, including allowances for specific adjustments to treatment, or that the treatment erroneously applies the guidelines, or that the treatment presents an unwarranted risk to the injured worker, then the employee or authorized treating physician may appeal the Utilization Review

(Rule 0800-02-06-.03, continued)

denial, and the Medical Director will make a written determination and communicate that determination in accordance with the provisions in 0800-02-06-.07.

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. Amendments filed October 31, 2016; effective January 29, 2017. Amendments filed July 1, 2022; effective September 29, 2022.*

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

(1) The utilization review organization shall communicate its determination to the parties within the timeframe established in Rule 0800-02-06-.06.

(2) If a utilization review appeal is filed with the Bureau, any recommended modification in a utilization review report will be considered a denial for the purpose of evaluating the appeal by the Bureau.

(3) If the utilization review determination is a denial of a recommended treatment, then the utilization review organization shall submit a written utilization review report in conformity with the requirements of subsection (4) of this Rule. If the utilization review determination is an approval of a recommended treatment, then the utilization review organization 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 (4) of this Rule. A utilization review report and other written documentation may be communicated through electronic means when available and appropriate.

(4) The utilization review organization physician's determination report shall contain a list of all medical information reviewed, the assessment of those records, the basis of the determination in accordance with the Bureau's adopted Treatment Guidelines, and the name and credentials of the utilization review physician. This information shall be sent to all parties. The utilization review communication to the authorized treating physician shall separately contain the information necessary for a peer-to-peer telephonic conference, or instructions on accessing an electronic portal for secure electronic communication between the utilization review physician and the authorized treating physician. This information shall be sent to the authorized treating physician and copied to the employer as defined in these rules.

(5) The utilization review determination report shall include an attestation statement and the signature of the utilization review physician that the physician has personally reviewed the list of medical information reviewed and made the determination. It shall include the utilization review physician's Tennessee license number, board certification, information and any other appropriate credential that supports the qualification of the physician.

(6) The utilization review report shall adhere to the following requirements:

(a) The utilization review organization shall 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 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 organization determines that the recommended treatment will be denied, the utilization review report must contain specific and detailed

(Rule 0800-02-06-.04, continued)

reasons for the denial, a listing of all the documents used to make the determination, and a record of any other communication between the utilization review physician and the requesting provider.

(c) The utilization review organization shall also include the name, address, and appropriate contact number or email address of the utilization review physician 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 Bureau. The utilization review organization 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 organization shall transmit any utilization review report to the Bureau. 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. Amendments filed October 31, 2016; effective January 29, 2017. Amendments filed July 1, 2022; effective September 29, 2022.*

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

(1) If the employer as defined in 0800-02-06-.01 disagrees with the authorized treating physician about the medical necessity of a recommended treatment, then the employer must participate in Utilization Review as defined in 0800-02-06-.01.

(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's Rules for Medical Payment, 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. Amendments filed October 31, 2016; effective January 29, 2017.*

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 organization within four (4) business days of the authorized treating physician's notification of the recommended treatment, subject to subsection (5) of this Rule. The four (4) business day interval begins when the adjuster receives the medical record that corresponds in time to the date of the treatment request. 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 and shall also, if requested, notify the Bureau. 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 adjuster shall respond to the requesting provider within four (4) business days of a receipt of a request for treatment, referral, second opinion, or consult. The four (4) business

(Rule 0800-02-06-.06, continued)

day interval begins when the adjuster receives the medical record that corresponds in time to the date of the treatment request. If the adjuster does not approve the request within four (4) business days, the adjuster shall immediately send the request to the utilization review organization and notify all parties. The adjuster shall send to the utilization review organization all pertinent medical records corresponding to tests or treatments paid for by the insurer in the past twelve (12) months and any communications necessary for the utilization review organization to complete its determination. This shall include but not be limited to the Form C35-A containing current and complete information of the employer, the names and contact information for the injured worker, the adjuster, the adjuster's supervisor, the compliance contact, and the attorneys. If there is no existing compliance contact email, the email for the adjuster's supervisor, the office manager or other liaison shall be listed. The medical records shall be in chronological or reverse chronological order, free of duplicates, one-sided, free of fax confirmation sheets and free of billing statements. The organization of the medical records may be accomplished by the utilization review organization. The employer may be subject to sanctions and/or civil penalties pursuant to Rule 0800-02-06-.10 of this Chapter.

(3) The utilization review organization 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 the determination is a denial, the utilization review report shall list all records and supplemental material reviewed by the utilization review organization. Upon request, the authorized treating physician or employee may obtain copies of any such records and supplemental material reviewed by the utilization review organization. The utilization review report shall also include an appeal form prescribed by the Bureau on which the utilization review organization 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's certification number issued by the Bureau. If the utilization review organization fails to comply with this subsection, then the utilization review organization may be subject to sanctions and/or civil penalties pursuant to Rule 0800-02-06-.10 of this Chapter.

(4) If a denial of the recommended treatment is appealed to the Bureau, then the employer as defined in these rules shall send a copy of the utilization review report and all records reviewed by the utilization review organization to the Bureau within five (5) business days of a request from the Bureau.

(5) When the adjuster receives notification of an appeal being filed with the Bureau, the adjuster shall send to the Bureau, within (5) five business days, the same records as sent to the utilization review organization, including the medical records for the past twelve (12) months, the complete and current Form C35-A and the utilization review organization determination report, including the utilization review physician's report containing the medical rationale for the denial. These shall be sent to the Bureau without duplicates or billing and fax records and in chronological or reverse chronological order, one-sided, containing the medical records, diagnostic studies, and medical correspondence for one calendar year before the date of the denial/modification determination. These record requirements may be met by sending the documents that were reorganized by the utilization review organization. The employer may be subject to sanctions and/or civil penalties pursuant to Rule 0800-02-06-.10 of this Chapter.

(6) An approval of a recommended treatment by the employer's utilization review organization shall be final and binding on the parties for administrative purposes.

(7) When there is a dispute over a request for information, the following timeframes shall apply:

(a) If the employer or utilization review organization does not possess all necessary information in order to evaluate the recommended treatment and render the utilization

(Rule 0800-02-06-.06, continued)

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 organization receives the necessary information or until the timeframe set forth in the preceding sentence expires, whichever occurs first.

(b) Denials by a utilization review organization 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 Bureau. If the Bureau finds that the employer's or utilization review organization's request did not contain the necessary information, then the employer or utilization review organization 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 organization, 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.

(8) 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 organization and what, if any, conditions shall apply to such authorization.

(b) If requested by the Bureau, 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 shall forward such determination to the Bureau. The employer shall also forward the notification described in subsection (6)(a) above, if applicable.

(9) (a) The utilization review decision to deny a recommended treatment shall remain effective for a period 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.

(b) A determination by the Bureau of a utilization review appeal, whether to uphold, overturn, or modify, shall be effective for six (6) months unless significant new material medical information, as determined by the Administrator or Administrator's Designee, is presented to require a new utilization review determination by the utilization review organization or the Bureau on appeal.

Authority: *T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126, and 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. Amendments filed October 31, 2016; effective January 29, 2017. Amendments filed July 1, 2022; effective September 29, 2022.*

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 Bureau that informs the employee as defined in these rules and authorized treating physician how to request an appeal with the Bureau. The employee or authorized treating physician shall have thirty (30) calendar days from receipt of the initial denial or the denial on reconsideration by an employer as defined in these rules to request an appeal with the Bureau. The form and accompanying instructions provided shall be the current form and instructions adopted by the Bureau and posted on the Bureau's website. The Medical Director may extend the time to appeal for good cause.

(2) Upon receipt of an appeal request by an employee or authorized treating physician:

(a) The Bureau or its designated contractor shall conduct the utilization review appeal. The Bureau or its designated contractor may contact the authorized treating physician for the purpose of obtaining any necessary missing information. The Bureau or its designated contractor shall determine the medical necessity of the recommended treatment as soon as practicable after receipt of all necessary information. The Bureau or its designated contractor shall then transmit such determination to the authorized treating physician, employee, and employer. The determination of the Bureau 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 Bureau, then any party not providing such information when requested by the Bureau 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 Bureau 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.

(3) If the determination of the Bureau 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. The penalty provisions of T.C.A. §§ 50-6-238 and 50-6-118 shall apply to these determinations issued pursuant to this subsection (3).

(4) For dates of injury on or after July 1, 2014, if the determination of the Medical Director is to approve part or all of the recommended treatment, then 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, including medications, has been approved and request that the procedure or treatment be scheduled. The penalties for noncompliance with this subsection are those set forth in T.C.A § 50-6-118.

(Rule 0800-02-06-.07, continued)

(5) A determination of denial is effective for a period of 6 months from the date of the determination as set forth in Rule 0800-02-06-.06(7).

(6) For dates of injury on or after July 1, 2014, notwithstanding the provisions of subsection (4), if any party, including an employee, employer, or a carrier, disagrees with a determination of the Medical Director's recommended or denied treatment, then the aggrieved party shall file a Petition for Benefit Determination (PBD) with the Court Of Workers' Compensation Claims within fifteen (15) calendar days of the receipt of the determination to request a hearing of the dispute in accordance with applicable statutory provisions. To avoid a penalty for non-compliance with the Medical Director's order, an employer who files a Petition for Benefit Determination (PBD) shall also request a stay of enforcement from the Court of Workers' Compensation Claims pending the outcome of the Petition for Benefit Determination (PBD).

(7) For dates of injury prior to July 1, 2014, if the determination of the Medical Director is to approve part or all of the recommended treatment, and an order for medical benefits is issued by the Bureau, within fifteen (15) calendar days of the receipt of the order the insurance carrier is required to inform the provider that the procedure and/or treatment, including medications, has been approved and request that the procedure or treatment be scheduled. The penalties for noncompliance with this subsection are those set forth in T.C.A § 50-6-238 [Applicable to injuries occurring prior to July 1, 2014]. The determination of the Medical Director is final for administrative purposes. If the employer disagrees with the determination, the employer may file a Request for Mediation (RFM) with the Bureau or civil action with a court of proper jurisdiction and shall request a stay of enforcement from the Bureau penalty program pending the outcome of the Request for Mediation (RFM) or civil action in a court of proper jurisdiction.

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

Authority: *T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126, 50-6-204, 50-6-233, and 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. Amendment filed June 30, 2015; effective September 28, 2015. Amendments filed October 31, 2016; effective January 29, 2017. Amendments filed July 1, 2022; effective September 29, 2022.*

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

(1) All utilization review organizations must file with the Bureau the Utilization Review Notification form (Form C-35) electronically within three (3) business days 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.

(2) All utilization review organizations must file with the Bureau the Utilization Review Closure form (Form C-36/C-37) electronically for each C-35 filed within three (3) business days following the conclusion of utilization review services on an employee's workers' compensation claim.

(Rule 0800-02-06-.08, continued)

(3) If requested by the Bureau, a utilization review organization shall be required to file an annual report with the Bureau detailing the utilization review organization's activities.

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. Amendments filed October 31, 2016; effective January 29, 2017.*

0800-02-06-.09 SUBCONTRACTORS.

(1) A utilization review organization shall be responsible for any utilization review physician(s), registered nurse(s), or other utilization review organization(s) with whom the utilization review organization 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. A utilization review organization shall be liable for all sanctions and/or civil penalties contained in this Chapter whenever its subcontractor violates any provision contained herein.

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. Amendments filed October 31, 2016; effective January 29, 2017. Amendments filed July 1, 2022; effective September 29, 2022.*

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

(1) Failure by an employer, insurer, third party administrator, or utilization review organization 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) per violation at the discretion of the Administrator. The Bureau 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 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).

(2) 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.

(3) Use of utilization review by an employer, carrier, or utilization review organization in an excessive or punitive manner, including but not limited to unjustified, repetitive, or poorly-supported utilization review activity as determined by the Administrator, where there has been a documented pattern by the employer, carrier, or utilization review organization, including attempts to force closure or alteration in a claim status, shall subject such party to a penalty of not less than fifty dollars ($50.00) nor more than five thousand dollars ($5,000.00) per violation at the discretion of the Administrator.

Authority: *T.C.A. §§ 4-5-314, 50-6-102, 50-6-118, 50-6-124, 50-6-126, and 50-6-233 and Public Chapters 282 & 289 (2013).* ***Administrative History:*** *Original rule filed March 5, 1993; effective April 19,*

(Rule 0800-02-06-.10, continued)
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. Amendments filed October 31, 2016; effective January 29, 2017. Amendments filed July 1, 2022; effective September 29, 2022.

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 or otherwise comply with the decision.

(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 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 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 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 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. Amendments filed October 31, 2016; effective January 29, 2017.*

0800-02-06-.12 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 4-5-203, 50-6-102, 50-6-124, 50-6-126, 50-6-204, 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 filed August 14, 2009; effective November 12, 2009. New rule filed March 25, 2013; effective June 23, 2013. Repeal filed December 26, 2013; effective March 26, 2014.*

0800-02-06-.13 REPEALED.

Authority: *T.C.A. §§ 4-5-202, 4-5-203, 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 filed August 14, 2009; effective November 12, 2009.*

0800-02-06-.14 PEER-TO-PEER COMMUNICATIONS.

This section provides for peer-to-peer communications. It applies to all treatment requests that have been denied or modified through utilization review.

(1) All denials or modifications of requests for treatment shall be made by a utilization review organization in accordance with this Rule 0800-02-06.

(2) Except as modified in this section, this applies to all recommended treatments (therapies, medications, diagnostic studies, procedures, referrals, consultations, and second opinions)

(Rule 0800-02-06-.14, continued)

for which approval by an employer (as defined in T.C.A. 50-6-102 and Rule 0800-02-17-.03) is necessary under Rule 0800-02-06.

(3) If, through utilization review, the employer or the utilization review organization on behalf of the employer, denies or modifies a request for recommended treatment, the authorized treating physician may request reconsideration of the denial to include a peer-to-peer conference with a utilization review physician designated by the utilization review organization. The timeframe for the peer-to-peer conference shall be within ten (10) days of the receipt of the request for a peer-to-peer conference being received by the adjuster or the utilization review organization. The denial notification sent by the utilization review organization shall provide the necessary information for the authorized treating physician to establish a request for the peer-to-peer conference. The request for the peer-to-peer conference shall be made by electronic communication to the contact listed on the denial notification. If the utilization review organization offers both electronic communication and telephonic communication, the authorized treating physician must specify which reconsideration option they choose in their electronic communication to the utilization review organization contact listed on the denial notification. The telephonic conference may be an interactive audio/video conference by mutual consent. If the authorized treating physician chooses telephonic communication, the authorized treating physician shall provide the following information in the electronic communication to the utilization review organization:

(a) The telephone number for the utilization review physician to call and the name of the authorization treating physician or designee, if any;

(b) The date for the conference not less than two (2) business days nor more than seven (7) business days from the date of receipt of the request by the utilization review organization; and

(c) Three (3) two (2)-hour periods on the date specified in accordance with (b) above during which the requesting medical provider or authorized treating physician (or designee) will be available to participate in the conference between the hours of 8:00 A.M. and 5:00 P.M. (Central Time), Monday through Friday, holidays excluded.

(4) The designated utilization review physician (who may not be the physician who performed the review) shall have reviewed and have available all of the medical information and records used in making the initial determination including any further information requested by the authorized treating physician, utilization review organization and/or utilization review physician before the call.

(5) As an alternative to the telephone or interactive audio/video conference, the utilization review organization may utilize an interactive web/email portal application for the peer-to-peer conference under the same time frames as (3). This alternative conference shall be initiated within two (2) business days of the authorized treating physician's request for this method of communication and shall provide for two (2) or more explanations if appropriate or necessary from the authorized treating physician and two (2) or more responses from a utilization review physician if appropriate or necessary to the authorized treating physician.

(6) Failure of the reviewing physician designated by the utilization review organization to participate in the peer-to-peer telephonic conference during the date and time specified or in the electronic communication option, unless a second good faith effort by the utilization review organization has occurred, shall result in the approval of the requested non-invasive treatment, medication, diagnostic study, referral, second opinion or consult unless good cause exists for the failure to participate. In the event of good cause for failure to participate in the peer-to-peer conference, the reviewing physician shall contact the requesting medical provider to reschedule the peer-to-peer conference. The rescheduled peer-to-peer

(Rule 0800-02-06-.14, continued)

conference shall be held no later than two (2) business days following the original conference date. This provision does not include invasive procedures for patient safety. A request for reconsideration as defined in these rules or the option of appeal to the Office of Tennessee Bureau of Workers' Compensation Medical Director should be utilized when failure to complete the peer-to-peer communication for invasive procedures occurs. If the reviewing physician is unavailable for any reason in the timeframe scheduled, an alternate reviewing physician with access to the file may participate in the call.

(7) Failure of the requesting authorized treating physician (or designee) to participate in the peer-to-peer conference during the time he/she specified availability or in the electronic communication option, if requested, may result in the denial of the requested treatment, referral, consult, or second opinion, unless good cause exists for the failure to participate. In the event of good cause for failure to participate in the peer-to-peer conference, the requesting provider shall contact the reviewing physician to reschedule the peer-to-peer conference. The rescheduled peer-to-peer conference shall be held no later than two (2) business days following the original conference date.

(8) A verifiable, complete, and accurate electronic record of all peer-to-peer telephonic contacts and interactive electronic communications, if any, shall be saved by the utilization review organization for a period of two (2) years from the date of receipt of the reconsideration request and shall be made available to the Bureau upon request. The authorized treating physician or their designee shall note in the medical records the outcome of all peer-to-peer communications. Once in the medical records, the communication becomes a permanent record. Such information shall be available to the Bureau upon request.

Authority: *T.C.A. § 50-6-124(c).* ***Administrative History:*** *New rule filed July 1, 2022; effective September 29, 2022.*

0800-02-06-.15 ANNUAL REPORTS FROM UTILIZATION REVIEW VENDORS.

Each year no later than March 1, utilization review organizations shall send the Bureau an annual report, as described below, for the preceding calendar year.

(1) The total number of requested utilization review organization determinations by utilization review organizations as defined in these rules;

(2) The results of the determinations categorized by denials, modifications, and approvals;

(3) The names of all utilization review physicians used by the utilization review organization during the preceding year and the number of reviews each utilization review physician performed, and if subcontracted, a list of utilization review physicians used by the subcontractor; and

(4) A record of all peer-to-peer conferences requested, the number of conferences completed, the results by number of upholds, modifications, and overturns of the completed conferences; the names of the utilization review organization physician(s) involved, and the number of conferences participated in by each utilization review physician.

(5) Failure to timely submit an annual report for a calendar year shall subject a party to a penalty of not less than fifty dollars ($50.00) nor more than five thousand dollars ($5,000.00) per violation at the discretion of the Administrator.

Authority: *T.C.A. § 50-6-415.* ***Administrative History:*** *New rule filed July 1, 2022; effective September 29, 2022.*