

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

**CHAPTER 0800-02-14
CLAIMS HANDLING STANDARDS**

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0800-02-14-.01 SCOPE OF RULES.

The provisions of this chapter shall apply to all employers, adjusting entities and providers of services related to workers' compensation claims in the State of Tennessee subject to provisions of the Workers' Compensation Law.

Authority: T.C.A. §§ 50-6-233, 50-6-415, and 50-6-419. **Administrative History:** Original rule filed December 15, 1997; effective February 28, 1998. Amendments filed May 4, 2018; effective August 2, 2018.

0800-02-14-.02 DEFINITIONS.

- (1) "Adjusting Entity" means a trade or professional association, managing general agency, pool, third party administrator and/or insurance company licensed to write workers' compensation insurance in Tennessee and shall also mean a self-insured Employer or group self-insured Employers possessing a valid certificate of authority from the commissioner of commerce and insurance pursuant to T.C.A. § 50-6-405.
- (2) "Adjuster," "claims adjuster," "med-only adjuster," or "claims handler" or "designee" 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, authorize and pay timely the correct payment of medical expenses, under the Tennessee Medical Fee Schedule, incurred by the injured worker in accordance with the provisions of Rules and Regs. 0800-02-17, 0800-02-18, and 0800-02-19 and/or makes settlement recommendations based on the insured's liability on behalf of an adjusting entity and self-insureds.
- (3) "Administrator" shall have the same definition of "Administrator" as in T.C.A. § 50-6-102.
- (4) "Assigned by Jurisdiction Number" means a unique number designated by the Bureau upon the request of an adjusting entity, to be used for EDI reporting purposes when the Employee's Social Security Number is unknown.
- (5) "Bureau" means the Tennessee Bureau of Workers' Compensation as defined in T.C.A. § 50-6-102, an autonomous unit attached to the Department of Labor and Workforce Development for administrative matters only, pursuant to T.C.A. § 4-3-1409.
- (6) "Claim" means a demand for something as due; an assertion of a right or an alleged right.
- (7) "Clearing House" shall have the same meaning as in Rules 0800-02-26 Definitions.

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

- (8) "Electronic Data Interchange" or "EDI" means the electronic communication method that provides standards for exchanging data via electronic means. The term "EDI" encompasses the entire electronic data interchange process, including the transmission, message flow, document format, and software used to interpret the documents using the standards established by the IAIABC and the Release Version accepted by the Bureau at the time of the filing.
- (9) "Electronic Form Equivalent" means the original document, provided on the Bureau's website, which is to be used when a sender reports required data via a paper document. When forms are reproduced, they shall be reproduced in their entirety, including instructions and shall not be modified without written consent of the Administrator. A form may be revised at any time at the discretion of the Administrator and will be available at no cost.
- (10) "Employee" shall have the same definition of "Employee" as in T.C.A. § 50-6-102.
- (11) "Employee Security ID" means a unique number assigned by the Bureau upon the accepted filing of an initiating FROI to be used rather than a Social Security Number for SROI filings to protect the privacy and security of the Employee.
- (12) "Employer" shall have the same definition of "Employer" as in T.C.A. § 50-6-102.
- (13) "First Report of Work Injury" or "FROI" means the initial report designed to notify the Bureau of the claim of an injury or illness.
- (14) "Form" means the document as is available on the Bureau's website on the date of the filing.
- (15) "Hospital" means the same as in Rules 0800-02-19 Definitions.
- (16) "IAIABC" means the International Association of Industrial Accident Boards and Commissions.
- (17) "Injury" and "personal injury" shall have the same definition of "injury" as in T.C.A. § 50-6-102.
- (18) "Insured" shall have the same definition of "Employer" as in T.C.A. § 50-6-102.
- (19) "Medical-Only" claim or "med-only" claim means a claim requiring medical attention, but which has no indemnity benefits due or paid. Any claim in which no indemnity benefits are due or paid, but which has medical treatment provided by any medical personnel qualifies the claim for medical only status, regardless of whether or not a bill is generated and regardless of whom pays for the medical care.
- (20) "Medical Provider" means an individual or entity involved in delivering healthcare services to Tennessee workers' compensation injured Employees, that play a role in diagnosing, treating, and managing the health and well-being of injured workers and includes physicians, surgeons, nurses, physician assistants (PAs) nurse practitioners (NPs) dentists, pharmacists, therapists, mental health professionals, hospitals and clinics, diagnostic service providers, and allied health professionals including but not limited to medical technologists, radiologic technologists, and others who support medical care to injured Employees.
- (21) "Subsequent Report of Injury" or "SROI" refers to the group of transactions of workers' compensation claim processing filed, via EDI, when required after an accepted FROI that typically report the benefit, payment, return to work, and closure data.
- (22) "Trading Partner" means an entity approved by the Bureau to exchange data electronically with the Bureau on behalf of an adjusting entity.

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

Authority: T.C.A. §§ 50-6-102, 50-6-113, and 50-6-233 **Administrative History:** Original rule filed December 15, 1997; effective February 28, 1998. Amendments filed May 4, 2018; effective August 2, 2018. Amendments filed August 12, 2025; effective November 10, 2025.

0800-02-14-.03 GENERAL REQUIREMENTS.

- (1) Any Employer or adjusting entity that knowingly, willfully and intentionally causes a claim to be paid under any health or sickness and accident insurance or that fails to provide reasonable and necessary medical treatment, including a failure to reimburse when the Employer or adjusting entity knew that the claim arose out of a compensable work-related injury shall be assessed a civil penalty of \$500.00. The Employer or adjusting entity shall not offset any benefit paid by that insurance against its temporary total disability benefit liability.

Each adjusting entity shall designate at least one (1) contact person to serve as a liaison between the entity and the Bureau. The designee must have the ability to provide information about claims assignments, status of payments and contact information for the adjusting entity's adjusters as well as the entity's primary EDI contact. The designee's name, title, direct phone number, email address, and mailing address shall be provided to the Bureau, on a form prescribed by the Bureau, in January of each year and within fifteen (15) calendar days of any change regarding the designee for that entity. Each January and July, the designee shall provide the Bureau, on a form prescribed by the Bureau, with the name(s), direct phone number(s), email address(es), and mailing address(es) for each individual adjuster that is performing duties covered by these Rules. Each separate act of not timely notifying the Bureau of a change in the designee or not timely providing the information, required in this subsection regarding adjusters shall constitute a separate violation and may subject the entity to assessment of a civil penalty, per Rule 0800-02-01-.10, for each separate act.

- (2) Each adjusting entity shall designate at least one (1) contact person to serve as a liaison between the entity, medical providers, injured workers or their representatives and the Bureau. The designee shall have the ability to provide information and resolution of disputes about billing/bill review, preferred provider networks, associated discounts and the status of payments concerning medical benefits afforded under the Act with an appropriate response within fifteen (15) calendar days from the date of the initial request for information or reconsideration. The designee's name, title, direct phone number, email address, and mailing address shall be provided to the Bureau, on a form prescribed by the Bureau, in January and July of each year and within fifteen (15) calendar days of any change regarding the designee for that entity. Each separate act of not timely notifying the Bureau of a change in the designee or not timely providing the information required in this subsection shall constitute a separate violation and may subject the entity to assessment of a civil penalty, per Rule 0800-02-01, for each separate act.
- (3) Each hospital or hospital system and clearing house shall, when requested by the Bureau, designate at least one (1) contact person to serve as a liaison between the entity, medical providers, and the Bureau. The designee shall have the ability to provide information and resolution of disputes about billing/bill review, preferred provider networks, associated discounts and the status of payments concerning medical benefits afforded under the Act. The designee's name, title, direct phone number, email address, and mailing address shall be provided to the Bureau, on a form prescribed by the Bureau, in January and July of each year and within fifteen (15) calendar days of any change regarding the designee for that entity.
- (4) Upon the written request of the Bureau's Medical Director, a medical provider shall designate at least one (1) contact person, within fifteen (15) calendar days of the request, to provide complete information about medical coding and the submission and reimbursement of

(Rule 0800-02-14-.03, continued)

medical bills, records requests and forms completion. The designee's name, title, direct phone number, email address, and mailing address shall be provided to the Bureau.

- (5) If an adjusting entity contracts with a trading partner to electronically file transactions with the Bureau on the entity's behalf, or uses a trading partner's software product for electronically sending transactions to the Bureau, a Trading Partner Agreement form, provided by the Bureau, must be fully completed and submitted to the Bureau via email to wc.edi@tn.gov annually, by July 1st of each year and within fifteen (15) calendar days of any change. If an adjusting entity does not contract with a trading partner to electronically file transactions, the adjusting entity must complete and submit the Trading Partner Agreement form in the same manner and frequency as stated above. The adjusting entity shall remain responsible for the timely filing of transactions required by this Rule, processing of acknowledgements, and any penalties and fines that may result from untimely electronic filings.
- (6) All adjusting entities or trading partners shall utilize anti-virus software to remove any viruses on all electronic transmissions prior to sending electronic transmissions to the Bureau. The adjusting entity or trading partner shall maintain the anti-virus software with the most recent anti-virus update files from the software provider. If the adjusting entity or trading partner sends a transmission that contains a virus which prevents the Bureau from processing the transmission, the transmission will not be considered as having been received.

Authority: T.C.A. §§ 50-3-702, 50-6-128, 50-6-233, 50-6-415, 50-6-419, and 56-47-103. **Administrative History:** Original rule filed on December 15, 1997; effective February 28, 1998. Amendments filed May 4, 2018; effective August 2, 2018. Amendments filed August 12, 2025; effective November 10, 2025.

0800-02-14-.04 CLAIMS REPORTING REQUIREMENTS.

- (1) All forms required by these rules must be filed with the Bureau via EDI, unless an electronic form equivalent is specifically allowed or required by the Bureau. Requirements for EDI reporting are posted on the Bureau's website.
- (2) The adjuster, when required, shall include the following information on every form it submits to the Bureau:
 - (a) The Employee's name.
 - (b) The Employee's date of birth.
 - (c) The month, day, and year of the Employee's injury or illness, in the following format: mm-dd-yyyy.
 - (d) For the initiating First Report of Injury (FROI), the Employee's social security number (SSN) as assigned by the Social Security Administration.
 1. If the Employee does not have a valid SSN, the adjusting entity shall contact the Bureau via email to wc.edi@tn.gov to request an "Assigned by Jurisdiction Number" in order to file the initiating FROI.
 2. If the adjusting entity later learns the correct SSN, the adjusting entity shall immediately notify the Bureau via EDI by filing the FROI 02.
- (3) The Employee Security ID shall be required on all filings submitted after an initial FROI has been accepted.
- (4) The adjusting entity shall ensure that all documents filed with the Bureau pursuant to this chapter, either by EDI or electronic form equivalent, are complete and legible.

(Rule 0800-02-14-.04, continued)

- (a) If a filing is not complete and error free, the filing shall be rejected. The adjusting entity shall immediately make the identified correction(s) and resubmit the filing to the Bureau. The filing will be considered “accepted” and in compliance with this section only when a complete and error free filing is received and not rejected by the Bureau.
 - (b) An adjusting entity may be subject to a penalty for any rejected EDI filing that is not immediately corrected, resubmitted and accepted by the Bureau.
 - (c) An adjusting entity will be subject to a penalty for any calendar month in which it fails to successfully transmit its documents with at least an 85% acceptance by the Bureau success rate for its filings. The assessment of this penalty will not preclude the assessment of additional penalties outlined in Rule 0800-02-13.
- (5) Every adjusting entity shall submit Tennessee’s First Report of Work Injury form via EDI to the Bureau as soon as possible in all cases where the reported injury results in the need for medical treatment, restricted work, the inability to work, or death, but no later than the time frames listed in T.C.A. § 50-3-702.
 - (6) Within two (2) business days of receiving a verbal or written notice of any injury from an Employer, the adjusting entity shall send a Notice of a Reported Injury and a copy of the Beginner’s Guide to Tennessee Workers’ Compensation on the forms prescribed by the Administrator to each Employee’s last known address via first class U.S. Mail.
 - (7) Adjusting entities shall follow the EDI requirements as posted on and/or linked from the Bureau’s website and in effect at the date of the filing.
 - (8) Initial decisions on compensability shall be made by the adjusting entity within fifteen (15) calendar days of the verbal or written notice of injury.
 - (a) In claims when compensability is questioned, adjusters shall contact all authorized medical providers, or their staff members, who have rendered medical services to an Employee within three (3) business days of an initial office visit to investigate details concerning the injury and treatment and make a preliminary compensability determination.
 - (b) Initial decisions regarding compensability can be changed as new or additional information is obtained by the adjusting entity. When compensability decisions are changed, all appropriate forms must be filed timely. If after conducting a reasonable investigation as required by these rules a claim is denied, the adjusting entity shall notify the Bureau within five (5) business days of reaching that decision by filing the required information via EDI and must provide the Employee or their representative, all authorized medical providers and the insured a non-EDI version of the Notice of Denial, available on the Bureau’s website, simultaneously with the notification to the Bureau. The notice shall include the basis for the denial. The adjusting entity is responsible for paying for all services rendered by each authorized medical provider not previously denied by the adjusting entity until the Bureau’s receipt of the notice of denial.
 - (c) An adjusting entity electing to deny a claim, in whole or in part, and terminate any or all future benefits after benefits have been paid in a claim shall submit an MTC SROI 04-Denial for a full denial of all further indemnity and medical benefits or an SROI MTC PD-Partial Denial for a denial of a specific indemnity or medical benefit via EDI within fifteen (15) calendar days of the due date of the first omitted payment.
 - (9) Adjusting entities shall file the required information via EDI within five (5) business days of the initial payment of benefits and within five (5) business days of a change or termination of the

(Rule 0800-02-14-.04, continued)

payment of compensation benefits. The adjusting entity shall also provide the Employee or their representative and the insured a non-EDI version of the Notice of Change or Termination of Compensation Benefits simultaneously with the notification to the Bureau and shall provide the explanation of the rationale upon which the modification was based.

- (10) For open claims, adjusting entities must submit MTC QT quarterly updates regarding the status of the claim until the case is closed, at which time it must submit a Final Report MTC FN.
 - (a) The initial MTC QT must be received no earlier than fourteen (14) calendar days prior to the end of the three (3) months from the date of the injury with subsequent filings due each three (3) months thereafter until the case is closed.
 - (b) If a Final Report MTC FN has been filed and the claim is being reopened to pay ongoing disability benefits, an MTC QT is due no later than the next three-month interval based on the date of the injury.
 - (c) The quarterly filing is not required when the First Report of Injury is for Notification Only (Claim Type N) or FROI 04 (with no PY, IP, EP, or AP on file) or SROI SX with DN0418-Suspension Reason Code-Full-S8 (Jurisdiction Change) has been accepted.
 - (d) If any indemnity or medical payments are made after a Claim Type N or FROI 04 has been accepted, the claim will re-open, the appropriate MTC will be required and an MTC QT will be due at the appropriate time.

Authority: T.C.A. §§ 50-6-205, 50-6-233, 50-6-415, and 50-6-419. **Administrative History:** Original rule filed December 15, 1997; effective February 28, 1998. Amendments filed May 4, 2018; effective August 2, 2018. Amendments filed April 29, 2021; effective July 28, 2021. Amendments filed July 1, 2022; effective September 29, 2022. Amendments filed August 12, 2025; effective November 10, 2025.

0800-02-14-.05 CLAIMS HANDLING AND INVESTIGATING.

- (1) The adjuster shall make verbal or written contact with the Employee within two (2) business days of receiving a verbal or written notice of any injury, including those considered to be “medical-only.” For “medical-only” claims, this contact is satisfied by the mailing of the Notice of Reported Injury and “Beginner’s Guide to Tennessee Workers’ Compensation Claims” referenced herein. In claims that involve lost time from work, this contact is not satisfied by the mailing of the documents referenced herein. The purpose of this contact is to:
 - (a) Provide each Employee with the adjuster’s name and contact information, which shall include the adjuster’s direct phone number, fax number, email address, and mailing address; and,
 - (b) Investigate the facts of the claim and obtain a history of prior claims, including work history, wages, and job duties.
- (2) Adjusters shall make personal, written or telephone contact with the Employer within two (2) business days of receiving the notice of the injury to verify details regarding the claim.
- (3) An adjuster assigned to a claim which had previously been assigned to a different adjuster shall make verbal or written contact with the Employee, the Employee’s attorney if appropriate and all known and authorized medical providers within two (2) business days of the assignment and shall provide to all the newly assigned adjuster’s name and contact information, which shall include that adjuster’s direct phone number, fax number, email address, and mailing address. In instances involving a mass transfer of files, such as might

(Rule 0800-02-14-.05, continued)

occur if an adjusting entity purchased or merged with another adjusting entity, the time required to provide this notice will be extended to seven (7) business days.

- (4) All Employers, adjusting entities and providers of services related to workers' compensation claims in the State of Tennessee subject to provisions of the Workers' Compensation Law shall provide the Bureau all information and documentation that is requested, and only that information that is requested, for the purposes of monitoring, examining, or investigating the entity's operations and processes within ten (10) calendar days unless the Bureau allows an extension of time.

Authority: T.C.A. §§ 50-6-101, 50-6-233, 50-6-415, and 50-6-419. **Administrative History:** Original rule filed December 15, 1997; effective February 28, 1998. Amendments filed May 4, 2018; effective August 2, 2018. Amendments filed August 12, 2025; effective November 10, 2025.

0800-02-14-.06 PAYMENT OF BENEFITS.

- (1) Disability and medical benefits are deemed paid when the correct payments have been addressed to the last known address of the proper recipient and deposited in the U.S. Mail or when funds are transferred to a financial institution for deposit in the proper recipient's account by approved electronic equivalent.
- (2) All temporary total disability benefits shall be issued accurately and timely to assure the injured Employee receives the benefits on or before the date they are due. To help ensure accuracy, Adjusters shall verify the average weekly wage of the Employee with the Employer consistent with the Bureau's requirements and the requirements of the Workers' Compensation Law. A Wage Statement, available on the Bureau's website, shall be filed with the Bureau upon request pursuant to Rule 0800-02-21.
 - (a) To be considered timely, initial temporary total disability payments must be paid to the Employee no later than fifteen (15) calendar days after the date the disability begins and every subsequent payment is made within consecutive fifteen (15) calendar day increments, until all temporary total benefits have been paid. Each payment must indicate the time period covered by the payment.
 - (b) All temporary partial disability benefits shall be issued timely, as per T.C.A § 50-6-207.
- (3) Funeral expenses, including burial or cremation expenses, must be paid within a reasonable period of time, not to exceed thirty (30) days from the date of submission of invoice.
- (4) All disability and death benefits shall be paid by check or direct deposit unless prior written permission for an alternative means of payment is given by the Administrator and the Employee or Employee's dependents have signed a written agreement allowing an alternative means.

Authority: T.C.A. §§ 50-6-201, 50-6-205, 50-6-225, 50-6-233, 50-6-237, 50-6-409, and 50-6-419. **Administrative History:** Original rule filed December 15, 1997; effective February 28, 1998. Amendments filed May 4, 2018; effective August 2, 2018. Amendments filed August 12, 2025; effective November 10, 2025.

0800-02-14-.07 MEDICAL COSTS.

- (1) All medical costs owed under the Tennessee Workers' Compensation Law shall be paid pursuant to the Medical Fee Schedule contained in Rules 0800-02-17, 0800-02-18 and 0800-02-19.

(Rule 0800-02-14-.07, continued)

Authority: T.C.A. §§ 50-6-204, 50-6-233, and 50-6-419. **Administrative History:** Original rule filed December 15, 1997; effective February 28, 1998. Amendments filed May 4, 2018; effective August 2, 2018.

0800-02-14-.08 RESOLUTION PROCESS.

- (1) The permanent impairment rating and date of maximum medical improvement determined by the treating physician, and other information needed to settle a claim shall be documented in writing on a form prescribed by the Administrator and provided, at no cost, to the Employee within thirty (30) calendar days of its receipt by the adjuster.
- (2) Adjusters shall make an offer of settlement in writing within thirty (30) calendar days of receipt of information specified above. If settlement is not agreed upon, a Benefit Review Conference or an Alternative Dispute Resolution, whichever is appropriate, may be requested by either party in accordance with the Bureau's rules.
- (3) All settlements shall be reduced to writing and shall be finalized by order or approval of an appropriate court, as required by the Workers' Compensation Law. A copy of the court order or Bureau approval and appropriate Statistical Data Form shall be filed timely with the Bureau.

Authority: T.C.A. §§ 50-6-206, 50-6-233, 50-6-237, 50-6-240, 50-6-244, and 50-6-419. **Administrative History:** Original rule filed December 15, 1997; effective February 28, 1998. Amendments filed May 4, 2018; effective August 2, 2018.

0800-02-14-.09 CLAIMS RESOLUTION FILING REQUIREMENTS.

- (1) The appropriate resolution form must be submitted to the Bureau in all claims when they are resolved.
 - (a) In matters concluded by settlement or resolved by trial, the Employer or the Employer's agent must file a fully completed appropriate version of the Statistical Data Form contemporaneously with the filing of the final order or settlement.
 1. To be considered fully complete, the form must contain all required data, as determined by the Bureau, and reflect information that is current as of the date the information is submitted to the court for approval, whether or not an appeal of the matter is anticipated or filed.
 2. The Employee and any agent of the Employee must cooperate with the adjusting entities in completing the Statistical Data Form.
 - (b) In matters not concluded by settlement or resolved by trial, adjusting entities must submit the required information via EDI within thirty (30) days following the final payment of compensation. The filing must include all compensation benefits paid on a claim, including all disability benefits, medical expenses (including but not limited to in-patient, out-patient, pharmacy, case management, therapy, and others), death benefits and funeral expenses, and legal costs.
- (2) A fully completed appropriate version of the Statistical Data Form is also required for every worker's compensation matter even if the only issue resolved is the closing of future medical benefits that had remained open pursuant to a prior order. This requirement applies even if a Statistical Data Form was filed at the time of submission of the prior order. The subsequent Statistical Data Form should reflect only the amount paid or being paid since the filing of the last Statistical Data Form.

(Rule 0800-02-14-.09, continued)

- (3) Pursuant to T.C.A. § 50-6-244, an order of the court is not final until the Statistical Data Form has been completed and filed with the appropriate clerk of the court or Bureau office.
- (4) If the Administrator or the Administrator's designee determines that an Employer or the Employer's agent fails to fully complete or timely file the Statistical Data Form, the Bureau may assess a civil penalty against the offending party not to exceed one hundred dollars (\$100) per violation. A party assessed a penalty by the Administrator pursuant to this subsection may appeal the penalty by requesting a contested case hearing pursuant to Rule 0800-02-13.

Authority: T.C.A. §§ 50-6-206 [Applicable to injuries occurring prior to July 1, 2014], 50-6-233, 50-6-244, and 50-6-419. **Administrative History:** Original rule filed December 15, 1997; effective February 28, 1998. Amendments filed May 4, 2018; effective August 2, 2018. Amendments filed April 29, 2021; effective July 28, 2021. Amendments filed August 12, 2025; effective November 10, 2025.

0800-02-14-.10 ENFORCEMENT.

- (1) The Bureau has the authority to monitor and audit the performance of adjusters and adjusting entities to ensure compliance with the Workers' Compensation Law and Bureau Rules as often as it deems necessary which includes, but is not limited to, the review of the following:
 - (a) Ongoing review of data provided to the Bureau by adjusting entities;
 - (b) Timeliness, completeness and accuracy of all filings with the Bureau in any format;
 - (c) Timeliness and accuracy of indemnity payments;
 - (d) Timeliness and accuracy of payments to medical providers in accordance with the provisions of the Medical Fee Schedule;
 - (e) Denied claims;
 - (f) Timeliness and accuracy of the provision of a panel of physicians;
 - (g) The alleged or suspected harassment, coercion or intimidation of any party;
 - (h) Timeliness of the response to a Request for Assistance, Petition for Benefits Determination or any equivalent form;
 - (i) Timeliness of the compliance with an Order from a Judge of the Court of Workers' Compensation Claims or Workers' Compensation Appeals Board, a Workers' Compensation Specialist, Administrative Law Judge, or an Administrator's Designee;
 - (j) Claims-handling practices;
 - (k) Timeliness of authorizing medical treatment and medications;
 - (l) Mailing of the Notice of a Reported Injury;
 - (m) Mailing of the Notice of Employer Rights and Responsibilities in a Workers' Compensation Claim required by Rule 0800-02-01 to the Employer;
 - (n) Timeliness and accuracy of notifying all appropriate parties of the change of an adjuster; and,

(Rule 0800-02-14-.10, continued)

- (o) Timeliness of compliance with an order of a Utilization Review Appeal determination in accordance with Rules and Regs. 0800-02-06.
- (2) Reports resulting from the Bureau's monitoring, examination or investigation conducted under this chapter are considered public records and may be shared in any means deemed appropriate by the Bureau and may include publicizing those adjusting entities that exceed or fail to meet the Bureau's established thresholds for claims handling excellence.
- (3) In addition to other penalties provided by applicable law and regulation, violations of any of the above rules shall be subject to enforcement by the Administrator pursuant to T.C.A. § 50-6-419(c).

Authority: T.C.A. §§ 50-6-233, 50-6-415, and 50-6-419. **Administrative History:** Original rules filed May 4, 2018; effective August 2, 2018. Amendments filed August 12, 2025; effective November 10, 2025.

0800-02-14-.11 FRAUD.

All provisions regarding the detecting, prosecuting, and/or preventing of workers' compensation fraud shall be governed by T.C.A. § 50-6-127 and Title 56, Chapter 47.

Authority: T.C.A. §§ 50-6-127, 50-6-419, and 56-47-103. **Administrative History:** Original rules filed May 4, 2018; effective August 2, 2018.