

**RULES  
OF  
TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT  
DIVISION 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) "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 or the Bureau.
- (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 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 is open for business.
- (6) "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.
- (7) "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) "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.

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

- (9) "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) "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."
- (11) "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.
- (12) "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;
- (13) "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.
- (14) "Parties" means the employee, authorized treating physician, employer, and their legal representatives as those terms are defined herein.
- (15) "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.
- (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 shall not mean utilization review as defined by Rule 0800-02-06-.01(20).

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

- (17) "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) "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 effective on January 1, 2016, and periodically updated as new information warrants.
- (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. "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 Rule 0800-02-06-.01(16). 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.
- (21) "Utilization review agent/organization" means an individual or entity authorized to do business and provide utilization review services in Tennessee. All Utilization review 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).

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

#### **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

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

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.
- (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, 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

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

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 an advisory medical practitioner 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 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.

#### **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, 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 report shall adhere to the following requirements:

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

- (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 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 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 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.

#### **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 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

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

- 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 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.
  - (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) 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.
  - (4) An approval of a recommended treatment by the employer's utilization review organization 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 organization does not possess all necessary information in order to evaluate the recommended treatment and 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 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 pertain to 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.
  - (6) Employer's obligations upon receipt of utilization review determination:

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

- (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.
- (7)
- (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) 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. Amendments filed October 31, 2016; effective January 29, 2017.

#### **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 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 a denial by an employer as defined in Rule 0800-02-06-.01(8) 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.

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

- (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.
  - (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) 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 may file a Petition for Benefit Determination (PBD) with the Court Of Workers' Compensation Claims within seven (7) business days of the receipt of the determination to request a hearing of the dispute in accordance with applicable statutory provisions.
  - (7) 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, 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,

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

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.

#### **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.
- (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 advisory medical practitioner(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.

#### **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).

(Rule 0800-02-06-.10, continued)

- (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.

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

#### **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.