Workers' Comp

September 2022 Utilization Review Compliance Update

September 28, 2022
11 MIN READ

As your utilization review (UR) vendor, we want to keep you informed of regulation updates that impact the UR business. If you have any questions about any of the information presented, please do not hesitate to contact your client account manager. Or you may reach out to a member of the Genex UR Compliance team whose information is provided at the end of this document.

Tennessee Rule Updates

Tennessee UR is governed by Chapter 0800-02-06 of the TN Department of Labor and Workforce Development Bureau of Workers' Compensation

- These rules will be on the agenda of the Joint Government Operations Committee at their September rule review on September 26, just a few days prior to the effective date
- The chapter 0800-02-06 filing is set to become effective 9.29.2022 if it is approved and not withdrawn or stayed by the Joint Government Operations Committee

The update includes the following definition changes:

- **Removes:** "Advisory Medical Practitioner" term
- **Adds:** "Utilization Review Physician" term; This 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.
- **Adds:** "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 able to understand the rationale and current medical evidence for the request. The determination of same or similar specialty shall by made by the Administrator.
- **Adds:** "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.

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Changes to the contents of the utilization review report include:

- **Adds:** 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 is 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.
- **Adds:** 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.
- **Revises:** 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.

Changes to time requirements include:

- **Revises:** 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. 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.
- **Adds:** 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 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 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.

- *The Genex UR TAT clock still starts when we receive the request from the adjuster and remains 7BD.*
- **Adds:** 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 reviewer 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 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.

Appeals of utilization review decisions:

- **Revises**: Appeals with the Bureau shall be made within thirty (30) calendar days from receipt of the initial denial or the denial on reconsideration.

Establishes annual utilization review data report:

- 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.
    - The total number of requested utilization review organization determinations by utilization review organizations as defined in these rules;
    - The results of the determinations categorized by denials, modifications, and approvals;
    - 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
    - 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 UR physician.
    - Failure to timely submit and annual report for a calendar year shall subject a party to a penalty of not less than fifty dollars nor more than five thousand dollars per violation at the discretion of the Administrator.

Sanction and civil penalties:

- **Adds**: Use of utilization review by an employer, carrier, or utilization review organization in an excessive or punitive manner, included 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.

Peer-to-peer communications:

- **Adds:** This section 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) for which approval by an employer is necessary.
    - (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 URO 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 URO:
        - (a) The telephone number for the UR 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 the receipt of the request by the URO; and
        - (c) Three (3) two – hour periods on the date specified in accordance with (b) above during which the requesting medical provider authorized treating physician (or designee) will be available to participate in the conference between the hours of 8:00AM and 5:00PM Central Time, Monday through Friday, holidays excluded**.**
    - (4) The designated UR physician (who may be different than the physician who performed the review) shall have reviewed and have available all the medical information and records used in making the initial determination including any further information requested by the authorized treating physician URO and/or UR physician before the call.
    - (5) The URO may utilize an interactive web/e-mail portal application for the peer-to-peer conference as an alternative to the telephone or interactive audio/video conference under the same timeframes as (3). This alternative conference shall be initiated within two business days of the request for this type of communication and shall provide for two or more explanations if appropriate or necessary from the authorized treating physician and two or more responses from a UR physician if appropriate or necessary to the authorized treating physician.
    - (6) Failure of the reviewing physician designated by the URO to participate in the peer-to-peer conference during the date and time specified, unless a second good faith effort by the URO has occurred, shall result in the approval of the treatment requested unless good cause exists for the

failure to participate. If there is good cause, the reviewing physician shall contact the requesting medical provider to reschedule the conference. The rescheduled conference shall be held no later than two 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 specified may result in the denial of the requested treatment unless good cause exists for the failure to participate. If there is good cause, the requesting provider shall contact the reviewing physician to reschedule. The rescheduled peer-to-peer conference shall be held no later than two 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 URO for a period of two 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.

Questions?

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