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# Rulemaking Hearing Rule(s) Filing Form

*Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing. TCA Section 4-5-205*

**Agency/Board/Commission:** Labor and Workforce Development  
**Division:** Workers' Compensation  
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**Revision Type (check all that apply):**

- Amendment  
 New  
 Repeal

**Rule(s) Revised (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables. Please enter only ONE Rule Number/RuleTitle per row)**

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

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

Chapter 0800-02-06  
General Rules of the Workers' Compensation Program  
Utilization Review

New Rules

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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) "Act" means the Tennessee Workers' Compensation Act, T.C.A. §§ 50-6-101, et seq., as amended.
- (2) "Administrator" means the chief administrative officer of the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development, or the Administrator's designee.
- (3) "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 agent or the Department.
- (4) "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 Division to treat any injured employee for a work-related injury or condition.
- (5) "Business day" means any day upon which the Workers' Compensation Division is open for business.
- (6) "Commissioner" means the Commissioner of the Tennessee Department of Labor and Workforce Development, the Commissioner's Designee, or an agency member appointed by the Commissioner.
- (7) "Consultation fee" means a fee for a practitioner who provides consultation services to the Division for the purpose of determining an appeal pursuant to this Chapter. Such fee shall be prescribed by the Commissioner and posted on the division's website. Such fee shall not increase or decrease except after thirty (30) calendar days from the date a notice of increase or decrease is posted on the Division's website.
- (8) "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 Commissioner has contracted to provide utilization review, including peer review, for the Division, as referred to in T.C.A. § 50-6-124.

- (9) "Department" means the Tennessee Department of Labor and Workforce Development.
- (10) "Division" means the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development.
- (11) "Employee" means an employee as defined in T.C.A. § 50-6-102, but also includes the employee's representative or legal counsel.
- (12) "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 representative or legal counsel, as applicable.
- (13) "Health care provider" includes, but is not limited to, the following: licensed individual, chiropractor, dentist, physical therapist, physician, surgeon, 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
- (14) "Inpatient services" means services rendered to a person who is formally admitted to a hospital and whose length of stay exceeds twenty-three (23) hours.
- (15) "Medical Director" means the Medical Director of the Division appointed by the Commissioner pursuant to T.C.A. § 50-6-126, or the Medical Director's designee chosen to act on behalf of the Medical Director.
- (16) "Medical necessity" means health care services that a practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are in accordance with generally accepted standards of medical practice.
- (17) "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 also include hospital admissions for a patient whose length of stay does not exceed twenty-three (23) hours.
- (18) "Parties" means the employee, authorized treating physician and employer as those terms are defined herein.
- (19) "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.
- (20) "Recommended treatment" means the recommendation of the authorized treating physician to perform or refer treatments, procedures, surgeries, 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.
- (21) "Records" means medical records and reports regarding an employee's claim for workers' compensation benefits. Records include electronic imaging of such documents.
- (22) "Standard appeal fee" means a fee charged by the Division for the purpose of determining an appeal pursuant to this Chapter. Such fee shall be prescribed by the Commissioner and posted on the Division's website. Such fee shall not increase or decrease except after thirty (30) calendar days from the date a notice of increase or decrease is posted on the Division's website.
- (23) "Utilization review" means evaluating the quality and appropriateness of health care or health care services in workers' compensation cases pursuant to the timeframes, procedures, and requirements of this Chapter, 0800-02-06, and as defined in T.C.A. § 50-6-102. The employer shall be responsible for all

costs associated with utilization review and shall in no event obligate the employee, health care provider or Department to pay for such services.

(24) "Utilization review agent" means an individual or entity authorized to do business in Tennessee, having certified to the Commissioner of Commerce and Insurance pursuant to T.C.A. §§ 56-6-701, et seq., and registered with the Division.

Authority: T.C.A. §§ 50-6-102, 50-6-124, 50-6-126, and 50-6-233.

#### 0800-02-06-.02 Utilization Review System

(1) This Chapter shall apply to all recommended treatments 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 agent to sanctions and/or civil penalties as set forth in Rule 0800-02-06-.10. The Medical Director or a workers' compensation specialist may determine whether a utilization review was conducted in conformity with this Chapter and may determine that a utilization review is void.

(3) The Commissioner may provide or contract for certain utilization review services with a Contractor. The Contractor may provide any service allowed by T.C.A. § 50-6-124, including, but not limited to, reviewing utilization review services and providing peer review. The parties shall cooperate and provide any necessary medical information to the Contractor when requested, which shall not constitute a waiver of any applicable privilege or confidentiality.

(4) Any organization conducting utilization review for workers' compensation cases pursuant to this Chapter shall provide to the Administrator copies of any information provided to the Commissioner of Commerce and Insurance pursuant to T.C.A. § 56-6-704. Any organization conducting utilization review for workers' compensation cases must also register with the Division on a form prescribed by the Administrator. Failure to certify to the Commissioner of Commerce and Insurance and be registered with the Division prior to performing utilization review services may result in sanctions and/or civil penalties pursuant to Rule 0800-02-06-.10 of this Chapter.

(5) Subject to any applicable requirements of law concerning confidentiality of records, a utilization review agent shall provide the Division, including the Medical Director, with any appropriate utilization review records or permit the Division to inspect, review, or copy such records in a reasonable manner. The Division will maintain any required confidentiality of any personally identifying information concerning employees claiming workers' compensation benefits. Provision of these records pursuant to this rule shall not constitute a waiver of any applicable privilege or confidentiality.

(6) In no event shall an individual concurrently perform case management services, as set forth in Chapter 0800-02-07, and utilization review with regard to a single claim of work-related injury.

(7) Billing and payment for any medical services provided in conjunction with this Chapter shall be subject, as applicable, to the Division'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.

#### 0800-02-06-.03 Utilization Review Requirements

(1) In any case in which utilization review is undertaken, the utilization review agent shall make an objective evaluation of the recommended treatment as it relates to the employee's condition and render a determination concerning the medical necessity of the recommended treatment. A utilization review agent may contact the authorized treating physician regarding the recommended treatment pursuant to

applicable law; provided that such contact shall not constitute a waiver of any other applicable privilege or confidentiality.

(2) Upon initiation of utilization review, the authorized treating physician shall submit all necessary information to the utilization review agent and shall certify that the information is a complete copy of the health care provider's records and reports that are necessary for utilization review. The authorized treating physician shall also include the reason(s) for the necessity of the recommended treatment in such records and reports. The employer, or other payer, shall reimburse the authorized treating physician for the costs of copying and transmitting such records; provided that the costs do not exceed the amounts prescribed by T.C.A. § 50-6-204. If a dispute arises as to the necessity of information, then the parties shall proceed as set forth in Rule 0800-02-06-.06(5).

(3) Upon receipt of all necessary information, the initial utilization review decision may be determined by a licensed registered nurse whenever the recommended treatment is being approved. For all denials, the utilization review decision shall be determined by an advisory medical practitioner and communicated to the parties in a written utilization review report.

Authority: T.C.A. §§ 50-6-102, 50-6-124, 50-6-126, and 50-6-233.

#### 0800-02-06-.04 Contents of Utilization Review Report

(1) The utilization review agent shall communicate its determination to the parties within the timeframe established in Rule 0800-02-06-.06. If the utilization review determination is a denial of a recommended treatment, then the utilization review agent shall submit a written utilization review report in conformity with the requirements of subsection (2) of this Rule. If the utilization review determination is an approval of a recommended treatment, then the utilization review agent 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 (2) of this Rule. A utilization review report and other written documentation may be communicated through electronic means when available.

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

(a) The utilization review agent shall only consider the medical necessity, appropriateness, efficiency, and quality of the recommended treatment for the employee's condition.

(b) Whenever a utilization review agent determines that the recommended treatment will be denied, the utilization review report must contain specific and detailed reasons for the denial.

(c) The utilization review agent shall also include the name, address, phone number and qualifications of the advisory medical practitioner making a denial determination.

(d) All utilization review reports that deny a recommended treatment shall include an appeal form prescribed by the Division. The utilization review agent shall transmit a copy of the utilization review report and appeal form to the authorized treating physician, employee, and employer. Upon request, the utilization review agent shall transmit any utilization review report to the Division. Failure to include the appeal form in the utilization review report and transmit such to all parties may result in sanctions and/or civil penalties pursuant to Rule 0800-02-06-.10 of this Chapter.

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126, and 50-6-233.

#### 0800-02-06-.05 Mandatory Utilization Review

(1) The parties are required to participate in utilization review under this Chapter whenever a dispute arises as to the medical necessity of a recommended treatment.

(2) Utilization review is required to be performed pursuant to the requirements of this Chapter whenever it is mandated by T.C.A. § 50-6-124 or the Division's Medical Cost Containment Program, Medical Fee Schedule, or In-Patient Hospital Fee Schedule rules contained in Chapters 0800-02-17, 0800-02-18, and 0800-02-19, respectively.

0800-02-06-.06 Time Requirements

(1) If a recommended treatment requires utilization review, then an employer shall submit the case to its utilization review agent within three (3) business days of the authorized treating physician's notification of the recommended treatment, subject to subsection (5) of this Rule. The authorized treating physician's notification of the recommended treatment to the employer shall, at a minimum, be in a form that confirms transmission by showing the time and date of receipt (e.g., facsimile). The employer shall notify all parties upon submitting the case to its utilization review agent, and shall also notify any workers' compensation specialist assigned to the claim. If the employer fails to comply with this subsection, then the employer may be subject to sanctions and/or civil penalties pursuant to Rule 0800-02-06-.10 of this Chapter.

(2) The utilization review agent shall render the determination and communicate the determination in writing to the authorized treating physician, employee and employer within seven (7) business days of receipt of the case from the employer, subject to subsection (5) of this Rule. If a denial, the utilization review report shall list all records and supplemental material reviewed by the utilization review agent. Upon request, the authorized treating physician or employee may obtain copies of any such records and supplemental material reviewed by the utilization review agent. The utilization review report shall also include an appeal form prescribed by the Division on which the utilization review agent shall identify the state file number associated with the claim for which treatment is being recommended, if any, and shall identify the utilization review agent's certification number issued by the Division. If the utilization review agent fails to comply with this subsection, then the utilization review agent may be subject to sanctions and/or civil penalties pursuant to Rule 0800-02-06-.10 of this Chapter.

(3) If a denial of the recommended treatment is appealed, then the utilization review agent shall send a copy of the utilization review report and all records reviewed by the utilization review agent to the Division upon request.

(4) An approval of a recommended treatment by the employer's utilization review agent 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 agent does not possess all necessary information in order to dispute the recommended treatment or render the utilization review determination, then it shall immediately make a written request for such information to the authorized treating physician, who shall comply with the written request within five (5) 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 agent receives the necessary information or until the timeframe set forth in the preceding sentence expires, whichever occurs first.

(b) Denials for inadequate information may be appealed pursuant to Rule 0800-02-06-.07, at which time the authorized treating physician shall submit all information deemed to be necessary by the Division. If the Division finds that the employer's or utilization review agent's request did not pertain to necessary information, then the employer or utilization review agent may be subject to sanctions and/or civil penalties as set forth in Rule 0800-02-06-.10, at the discretion of the Commissioner. 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 agent, 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 Commissioner.

(6) Employer's obligations upon receipt of utilization review determination:

(a) Within three (3) business days of receiving a utilization review determination that denies the recommended treatment, the employer 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 agent and what, if any, conditions shall apply to such authorization.

(b) Within three (3) business days of receiving a utilization review determination that is either an approval or denial, the employer shall forward such determination to any workers' compensation specialist assigned to the claim. The employer shall also forward the notification described in subsection (6)(a) above, if applicable.

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126, and 50-6-233.

#### 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 Division that informs the employee and authorized treating physician how to request an appeal with the Division. The employee or authorized treating physician shall have thirty (30) calendar days from receipt to request an appeal with the Division.

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

(a) The Division shall conduct the utilization review appeal. The Division may contact the authorized treating physician for peer review purposes. The Division shall determine the medical necessity of the recommended treatment within twenty-five (25) business days after receipt of all necessary information. The Division shall then transmit such determination to the authorized treating physician, employee, and employer. The determination of the Division 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 Division, then the timeframe in subsection (a) shall be tolled until all such information is submitted and may subject any party withholding such information to sanctions and/or civil penalties as set forth in Rule 0800-02-06-.10, at the discretion of the Commissioner.

(c) The employer shall remit the standard appeal fee and/or the consultation fee to the Division. If the applicable fee is not received within ten (10) business days of the issuance of the Division's determination, a late fee of 10% of the applicable fee per day shall accrue until payment is received.

(3) If the determination of the Division is an approval of the recommended treatment, then a workers' compensation specialist shall issue an order for medical benefits. The penalty provisions of T.C.A. § 50-6-238(d) shall apply to orders issued pursuant to this subsection (3).

(4) If the determination of the Division is a denial of the recommended treatment, then the parties may file a Request for Benefit Review Conference or may request a waiver of the benefit review conference requirement, as applicable.

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

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126, 50-6-233, and 50-6-238.

#### 0800-02-06-.08 Utilization Review Forms

(1) All utilization review agents must file the Utilization Review Notification form (Form C-35) immediately upon initiation of utilization review services on an employee's workers' compensation claim. Only one form is necessary for each claim.

(2) All utilization review agents must file the Utilization Review Closure form (Form C-36/C-37) immediately following the conclusion of utilization review services on an employee's workers' compensation claim. Only one form is necessary for each claim.

(3) All utilization review agents must file an annual report on a form prescribed by the Division and accessible through the Division's website.

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126, and 50-6-233.

#### 0800-02-06-.09 Subcontractors

(1) A utilization review agent shall be responsible for any advisory medical practitioner(s) and registered nurse(s) with whom the utilization review agent subcontracts to perform utilization reviews. If a subcontractor performs a utilization review in accordance with the requirements of this Chapter, then the utilization review shall be treated as if performed by the contracting utilization review agent. A utilization review agent shall be liable for all sanctions and/or civil penalties contained in this Chapter whenever its subcontractor violates any provision contained herein.

(2) A utilization review agent may only subcontract with an advisory medical practitioner as defined in Rule 0800-02-06-.01(3) or registered nurse. All other subcontracting for utilization review services is prohibited and will result in the invalidity of such utilization review determination.

Authority: T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126, and 50-6-233.

#### 0800-02-06-.10 Sanctions and Civil Penalties

(1) Failure by an employer, insurer, third party administrator, or utilization review agent to comply with any requirement in this Chapter, 0800-02-06, including but not limited to applying utilization review when required and complying with the timeframes for utilization review, shall subject such party to a penalty of not less than one hundred dollars (\$100.00) nor more than one thousand dollars (\$1,000.00) per violation at the discretion of the Commissioner. The Division may also institute a temporary or permanent suspension of the right to perform utilization review services for workers' compensation claims, if the utilization review agent has established a pattern of violations.

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

(3) The penalty for failure to timely file the Form C-35 or Form C-36/C-37 in accordance with Rule 0800-02-06-.08 is twenty-five dollars (\$25) for each fifteen (15) calendar days past the initiation 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, and 50-6-233.

#### 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 Department 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 Commissioner within fifteen (15) calendar days of the issuance of the decision. This petition shall be considered a request for a contested case hearing within the Department pursuant to the Uniform Administrative Procedures Act, T.C.A. §§ 4-5-101, et seq., and the procedural rules of Chapter 0800-02-13 are incorporated as if set forth fully herein. The Department is authorized to conduct the hearing pursuant to T.C.A. § 50-6-118.

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

#### Repeals

Current Chapter 0800-02-06 General Rules of the Workers' Compensation Program- Utilization Review is hereby repealed in its entirety.

Authority: T.C.A. §§ 4-5-202, 4-5-203, 50-6-124, 50-6-126, and 50-6-233.

\* If a roll-call vote was necessary, the vote by the Agency on these rulemaking hearing rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Department of Labor and Workforce Development (board/commission/ other authority) on 7/7/09 (mm/dd/yyyy), and is in compliance with the provisions of TCA 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 02/26/09

Notice published in the Tennessee Administrative Register on: 03/13/09

Rulemaking Hearing(s) Conducted on: (add more dates). 05/05/09

Date: 8/5/09

Signature: James G. Neeley

Name of Officer: James G. Neeley

Title of Officer: Commissioner of Labor and Workforce Development



Subscribed and sworn to before me on: July 8, 2009

Notary Public Signature: Vickie H. Gregory

My commission expires on: December 31, 2012

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Robert E. Cooper, Jr.  
Robert E. Cooper, Jr.  
Attorney General and Reporter

8-11-09  
Date

**Department of State Use Only**

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PUBLICATIONS

Filed with the Department of State on: 8/14/09

Effective on: 11/12/09

Tre Hargett  
Tre Hargett  
Secretary of State

## Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. §4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

1) Comment: It is unnecessary to require the Advisory Medical Practitioner to have an active Tennessee license. It would lessen the pool of applicable physicians, which would decrease competition and increase costs at a time when 62% of total workers' compensation costs are medical benefits. These costs outweigh any benefits gained. Doctors increasingly look to national standards for guidance, while local standards of care are becoming antiquated. Moreover, there are many highly qualified physicians outside of the state of Tennessee.

In addition, individuals do not have to pass tests with Tennessee-specific questions in order to become physicians or board-certified. This requirement is also inconsistent with T.C.A. §§ 56-6-704 and 56-6-705. The advantage gained by having the physicians under the authority of the Tennessee Board of Medical Examiners is minimal, because the Board does not exercise meaningful oversight.

Response: The Tennessee-licensure requirement is important for two reasons. First, an Advisory Medical Practitioner who overrules a treating physician needs to be familiar with the standard of care in Tennessee. The Advisory Medical Practitioner's role amounts to directing the patient's care, albeit to a more limited degree than the treating physician. Accordingly, the Advisory Medical Practitioner needs to be licensed to provide services in Tennessee and be familiar with typical services rendered in Tennessee. Several commenters agreed with the rationale for this requirement.

Second, the State has no enforcement authority over out-of-state physicians who are not licensed in Tennessee. As such, the requirements and penalty provisions in the new rules would be useless against out-of-state physicians. Moreover, while this requirement is more stringent than T.C.A. §§ 56-6-704 and 56-6-705, several provisions of the new rules are more stringent than, but do not conflict with, the requirements of T.C.A. §§ 56-6-701, et seq., which applies to all utilization reviews, not just workers' compensation. The Commissioner of Labor and Workforce Development has the specific authority pursuant to T.C.A. § 50-6-124 to establish a system of utilization review for workers' compensation cases. Accordingly, these rules are necessary because, unlike regular health insurance, injured workers cannot choose their workers' compensation insurers and, thus, must rely more on workers' compensation statutes and rules, rather than coverage contracts and general statutes.

It is also important to note that a Tennessee-licensed physician does not have to reside or practice in the state. In addition, the Tennessee Department of Health estimates that there are 19,715 physicians that have active, Tennessee licenses. Accordingly, the applicable pool for Advisory Medical Practitioners appears to be substantial and the Division has not been presented with any empirical evidence that costs will be significantly increased because of a Tennessee-licensure requirement.

2) Comment: It is unnecessary for the Advisory Medical Practitioner to be of the same or similar specialty as the treating physician. Certain specialties may not have enough Tennessee-licensed physicians, which would increase costs to recruit appropriate physicians, make it difficult to comply with the time requirements, and could cause conflict-of-interest problems, especially in under-served specialties. The provision is vague and should be focused more on whether the practitioner is familiar with the recommended treatment rather than the specialty of the treating physician, since a treating physician can request a treatment that is not in his or her specialty. The Division should also keep a table or list of specialties that are "similar."

As an example, it is estimated that there are only 30 board-certified, fellowship trained spine surgeons in Tennessee (in either orthopaedic or neurosurgery). This requirement would significantly lessen the applicable pool for Advisory Medical Practitioners.

Response: It is necessary for an Advisory Medical Practitioner, who is able to overrule a treating physician's recommendation, to specialize in the same or similar general specialty. The Advisory Medical Practitioner should have professional experience in the same or similar general specialty if he or she is going to have the authority to deny the treating physician's recommendation, thereby directing the patient's care to some degree. The "specialty" requirement is clearer and more enforceable than a "treatment" requirement, which is not subject to

board-certification. Moreover, the same or similar general specialty standard has previously been approved by the General Assembly. See T.C.A. § 56-6-705. Several commenters agreed with the rationale for this requirement.

In response to the example, according to the databases of the American Board of Orthopaedic Surgery and the American Board of Neurological Surgery, there are currently approximately 550 physicians in Tennessee who are board-certified in orthopaedic surgery and approximately 120 physicians in Tennessee who are board-certified in neurological surgery. These numbers do not even include physicians who have Tennessee licenses, but do not have offices in Tennessee, who also may qualify as Advisory Medical Practitioners since the Advisory Medical Practitioner does not have to practice or reside in any particular geographical area.

While the new rules do require that a physician be Tennessee-licensed and board-certified in the same or similar general specialty, the new rules do not require any subspecialties or fellowship training. As noted above, the Tennessee Department of Health estimates that there are 19,715 physicians that have active, Tennessee licenses. Accordingly, the applicable pool for Advisory Medical Practitioners appears to be substantial.

3) Comment: The “board-certified” requirement should be clarified to mean those certifications recognized by the American Board of Medical Specialties.

Response: The Division does not wish to exclude other certifications, such as osteopathic certifications, which the General Assembly has recognized in prior legislation. See T.C.A. §§ 29-34-303, 63-9-106.

4) Comment: The requirement that the Advisory Medical Practitioner should be in the “same or similar general specialty” should be restricted to only “same specialty.” The Advisory Medical Practitioner should be equally credentialed as the treating physician whom they are reviewing.

Response: While the Division finds it necessary to limit the Advisory Medical Practitioner to the “same or similar general specialty,” a stricter limitation to “same specialty only” may be too restrictive. For example, a treating physician who is double board-certified could only be overruled by another physician with the same double board-certification if that requirement were adopted.

5) Comment: It is unnecessary to require that treating physicians be reimbursed for submitting necessary records. Currently, treating physicians sometimes bill for these records and receive payment, but if they are required to submit them by rule, then there should be no reimbursement.

Response: Under the new rules, it is largely the employer, or its insurance carrier, that opts to initiate utilization review. As such, if the employer, or its insurance carrier, wishes to engage in utilization review, then it should bear the costs. The copying fees will be subject to T.C.A. § 50-6-204, so that the treating physician will not be able to charge an exorbitant fee.

6) Comment: It would be appropriate to allow licensed practical nurses to perform the initial review and approval, rather than limiting it to only registered nurses. Due to a nursing shortage and the fact that they will not be allowed to deny treatment, it would not be necessary to require registered nurses.

Response: Requiring registered nurses to perform the initial review adds a level of protection to the process because registered nurses are required to exercise “substantial specialized judgment and skill.” See T.C.A. § 63-7-103(a)(1). On the other hand, licensed practical nurses are not “required to have the same degree of education and preparation as required of a registered nurse.” See T.C.A. § 63-7-108.

7) Comment: It is unnecessary that the utilization review report be accompanied by all records and other material reviewed by the utilization review agent. This will add administrative and mailing costs. The requirement appears to apply to approvals and denials. It would be preferable to only require a listing of the records reviewed in the report.

Response: The Division will clarify that a list of the records and other materials reviewed is acceptable rather than attaching the actual records and other materials. The employee or Division may request such materials, however, and the utilization review agent must then provide any such materials. The requirements for the utilization review reports do not apply to approvals though. The new requirements of T.C.A. § 50-6-204(a)(1) & (2) must also be followed.

8) Comment: Requiring the utilization review report to be automatically sent to the employee, employer, and treating physician creates undue costs.

Response: The parties must know what the outcome of the utilization review is. Transmitting the utilization review report by electronic means is satisfactory, and should reduce costs.

9) Comment: It is unclear as to whether the requirement to file the C-35 and C-36/37 forms applies to each utilization review performed or only to each claim. Are these forms online and can they be merged into one form? The forms may also need to be amended to include the utilization review outcome and to allow more procedure codes.

Response: The forms are only to be filed once for each claim, not for each instance of utilization review. The paper forms are available online and include inputs for the utilization review outcome and several procedure codes. Due to fiscal restraints, the forms accessible through the Division's online portal cannot be changed at this time, but the comment will be taken into consideration for the next time that there is an update to the system.

10) Comment: Requiring the utilization review agent to only consider the medical necessity of the recommended treatment is inconsistent with the statutory definition of utilization review. There is also a lack of explanation as to the manner of dealing with conditions that are not accepted as part of the injury.

Response: The statutory definition only allows review of the "necessity, appropriateness, efficiency and quality of medical care services." See T.C.A. § 50-6-102(17). The statutory definition does not allow for consideration of legal issues, such as causation or apportionment of liability. Injuries or conditions that are not part of the workers' compensation claim do not fall under these rules. Thus, the rules are purposely silent as to injuries and conditions that are not subject to the rules.

11) Comment: A self-insured employer may automatically direct all recommended treatments to its utilization review agent. Would that satisfy the requirement in 0800-02-06-.06(1) to send the recommendation to the utilization review agent within three business days?

Response: Yes, if the recommended treatment is automatically referred to the utilization review agent, then that step is satisfied. The self-insured employer would need to notify the parties, however, that it has initiated utilization review.

12) Comment: Is a utilization review agent bound to follow the seven business day timeframe in 0800-02-06-.06(2) or the two business day timeframe in T.C.A. § 56-6-705(a)?

Response: Whichever occurs first. The seven business day timeframe begins to run whether the utilization review agent has the necessary records or not, although this timeframe may be tolled for up to five business days after a request to the treating physician for records. On the other hand, the two business day timeframe only begins to run once the utilization review agent has all of the necessary records. Accordingly, the seven business day timeframe in the rules could expire before the two business day timeframe in T.C.A. § 50-6-705(a), and vice versa.

13) Comment: The new rules remove the utilization review agent's internal appeal process, which is unnecessary because companies accredited by the Utilization Review Accreditation Commission ("URAC") already have an efficient appeal procedure in place. Such an appeal could make the appeal to the Division unnecessary. The insurer will be responsible for paying a fee for the Division's appeal, whereas it may be more appropriate to have the losing party pay the fee. Treating physicians may have more incentive to not cooperate with the utilization review agent when an appeal to the Division that is paid by the insurer is readily available. The appeal to the Division should be optional after the internal appeal, and the appeal form can then be made available upon request.

Response: The new rules do not require nor prohibit the internal appeal process. The utilization review agent can still perform the internal appeal, but the employee or treating physician still has the option of appealing the initial denial to the Division within 30 calendar days of the initial denial. The Division's appeal is final and binding for administrative purposes regardless of the outcome of the utilization review agent's internal appeal, though the parties are free to withdraw the appeal to the Division upon receiving a reversal from the internal appeal. Moreover, since the employer, or its insurance carrier, initiates utilization review, then it should bear the

costs of the process. Any treating physician that refuses to cooperate with the utilization review agent will be subject to civil penalties.

14) Comment: The Division's appeal should be held to the same requirements as the utilization review agent's determination and should have to follow evidence-based guidelines as to "medical necessity." The Division may not have the resources to handle all of the appeals within the appropriate timeframes. The Division should have to transmit its decision within the 20-day timeframe as well. The Division should notify the appropriate person that is allegedly withholding information necessary for the appeal before a penalty is assessed.

Response: The Division is not held to the same requirements as the utilization review agent because the Division is a neutral decision-maker. See response to Comment 17 for a discussion on "medical necessity." While the Division will strive to handle all of the utilization review appeals in a timely fashion, the timeframe can be amended to 25 days to allow more time to consult with outside medical professionals when needed. The Division will transmit its decision immediately after such decision is made. Any party withholding information necessary for the Division's appeal will be notified as soon as possible and certainly before any penalty is assessed.

15) Comment: The new rules decrease the timeframe for appealing a civil penalty assessment from 30 calendar days to 15 calendar days, which is not enough time to effectively respond.

Response: The new rule will synchronize with the penalty program's rules that allow 15 calendar days to either comply with the penalty assessment or request a contested case hearing. Currently, the Division assesses various penalties that are subject to the 15-day timeframe. It is important to note that only the request for a contested case hearing must be within the 15-day timeframe, but the actual contested case hearing will then be scheduled for a later date.

16) Comment: The Division should keep a table of the specific records due from the treating physician, which would depend on the treatment involved. The utilization review agent should not be required to take any action until receiving the necessary records. The term "records" should include electronic imaging.

Response: A table of specific records would likely be incomplete and ever-changing. As such, the treating physician is required to send the records that he or she believes in good faith to be necessary and then the utilization review agent can request further records if necessary. The utilization review agent is required to request the missing, but necessary, records and can deny the treatment for lack of information if the utilization review agent does not receive those records within five days. "Records" will be clarified to include electronic imaging.

17) Comment: The term "medically necessary" is inadequate in its current form and should incorporate objective, evidence-based guidelines. Recommendations include adopting the guidelines of the American College of Occupational and Environmental Medicine ("ACOEM") or the definition of "medically necessary" from Blue Cross Blue Shield.

Response: While there are many reputable national guidelines available, the act of adopting or endorsing one over others will invariably lead to more problems when the favored guide is silent as to a certain condition or treatment. It is important to note that the treating physician does not have carte blanche and a utilization review agent may use these guidelines in making its own determination of "medically necessary."

18) Comment: Use of the term "employer" is unclear and inappropriate because the carrier or third party administrator is generally responsible for utilization review requirements. Penalties should not be assessed against entities that are not responsible for complying with utilization review requirements. The actual employer should not have to notify the parties when sending the recommendation to utilization review because the utilization review agent will be in contact with the treating physician and the recommendation should be required to go straight to the utilization review agent from the treating physician.

Response: The term "employer" includes self-insured employers, as well as insurance carriers, legal counsel, or other representatives. This definition can also be amended to include third party administrators. Essentially, the rules anticipate the "employer" being whichever individual or entity that is responsible for complying with the workers' compensation laws and regulations, which in most cases will not be the actual employer. Penalties would only be assessed against the entity that violated the rules. The responsible entity does need to send the notification, which is necessary in order to keep all parties informed of the process. Not every recommended

treatment will be reviewed by the utilization review agent and, thus, requiring the treating physicians to send all recommendations to a designated utilization agent would be inappropriate.

19) Comment: Overturned appeals should not result in civil penalties, which could induce cautious employers to authorize treatment that is denied and then appealed to the Division. Utilization review agents that are regularly overturned could be audited to ensure compliance with the rules.

Response: When the Division simply overturns a utilization review determination, it will not result in a penalty. There may be circumstances where certain requirements in the rules were not satisfied, which may result in penalties. The Division's disagreement with a properly-performed utilization review, however, will not result in a penalty. In addition, the penalty process is based on complaints received by the Division rather than audits.

20) Comment: The Department of Commerce and Insurance does not certify utilization review agents, rather utilization review agents certify to the Department of Commerce and Insurance that they are compliant with T.C.A. §§ 56-6-701, et seq.

Response: The rules will be amended to include this clarification.

21) Comment: It would be preferable for the Department of Commerce and Insurance and the Division of Workers' Compensation to share information so that a utilization review agent does not have to register with both entities. This would be more efficient and cost-effective.

Response: The Division's new rules are stricter in some ways than T.C.A. §§ 56-6-701, et seq. As such, utilization review agents will need to register with the Division so that the Division can ensure that the new requirements are being met. The Division will also need to have information about utilization review agents for tracking and contact purposes. There is no charge for the Division's registration.

22) Comment: The rules are silent as to national treatment guidelines and there have been indications that the Division may develop Tennessee-based guidelines. It may be appropriate to explicitly state in the rules that national guidelines are not endorsed by the Division.

Response: At this point, the Division is exploring the possibility of developing a Tennessee-based guideline. Until such a guideline is developed and adopted, however, the Division does not find it appropriate to endorse or prohibit any national guideline.

23) Comment: It is unnecessary to prohibit the same individual from performing utilization review and case management on the same claim because a merged model of such services is more efficient.

Response: Utilization review and case management serve very different functions and should not be performed by the same individual on the same claim. The objectiveness of utilization review may be compromised if performed by a case manager who has a working relationship with the patient and treating physician. The same company or entity may provide both of these services for a single claim, as long as both services are not performed by the same individual.

24) Comment: URAC provides extensive requirements for accreditation. The Division should accept URAC-accreditation in lieu of registration by the Division.

Response: The Division's new rules are stricter in some ways than URAC. As such, utilization review agents will need to register with the Division so that the Division can ensure that the new requirements are being met. The Division will also need to have information about utilization review agents for tracking and contact purposes.

25) Comment: Approvals of recommendations are usually provided through verbal notice, followed up in writing. This practice should continue to be allowed under the new rules. It is also unnecessary and burdensome for the employer and utilization review agent to send notifications to the parties during the process and to allow the Division to review records upon request.

Response: Employees and treating physicians need written documentation for situations where a dispute as to the utilization review outcome may later arise. Written notifications ensure that all parties are informed of the process and allow the Division to ensure compliance with the new rules. The requirements for a written approval are more informal than for a denial. This written documentation can also be transmitted via electronic means so

that there is no delay in treatment. Furthermore, the Division will need to review records when determining an appeal.

26) Comment: The definition of "practitioner" should include podiatrists and psychologists because they may order treatments related to workers' compensation claims as well.

Response: The term "authorized treating physician" is meant to be broad enough to include any health professional that may order workers' compensation treatment and will be clarified to that extent.

27) Comment: The definition of "recommended treatment" should include medications.

Response: Utilization review only applies to "medical care services." See T.C.A. § 50-6-102(17). "Medicine" is mentioned elsewhere in the statutes, but not in the utilization review definition. As such, it does not appear that the General Assembly intended for medications to be included in the "medical care services" to be reviewed.

28) Comment: The ability to contact the treating physician should extend to the nurses performing the initial review because they may need to engage in such contact as well.

Response: The utilization review agent, which includes registered nurses, is allowed to contact the treating physician and the rule will be amended so as not to confine it to "peer review." The new requirements of T.C.A. § 50-6-204(a)(1) & (2) must be followed though.

29) Comment: Rule 0800-02-06-.02, paragraphs (2) and (5) appear to conflict because paragraph (2) states that employers have the option of developing a utilization review system, whereas paragraph (5) states that utilization review is mandatory in some circumstances.

Response: Rule 0800-02-06-.02(2) will be amended to replace "may" with "shall."

30) Comment: The rules allow workers' compensation specialists to void utilization reviews even though they are non-medical professionals. If the rules are going to allow workers' compensation specialists to void utilization reviews, then there needs to be some guidance as to when it is appropriate. A utilization review performed in accordance with the rules should never be voided.

Response: A utilization review that is performed in accordance with the new rules will not be voided. A workers' compensation specialist will only void a utilization review when it fails to comply with the new rules.

31) Comment: The timeframes fail to recognize the difference between prospective, concurrent, and retrospective reviews and the different considerations of each. The timeframes should also be lengthened.

Response: The new rules are streamlined so that the same requirements apply to each type of review. This gives the system more consistency and predictability. The definition of "recommended treatment" can be amended to include emergency treatments for cases of retrospective review. The timeframes are reasonable and in accordance with several other states' requirements.

32) Comment: The Uniform Administrative Procedures Act ("UAPA") should apply to any penalties assessed under the new rules.

Response: The UAPA is referenced in 0800-02-06-.11 and the contested case hearing provisions do apply to any penalty assessed under the new rules.

33) Comment: The utilization review agent should be allowed to subcontract with nurses, as well as physical and occupational therapists, rather than restricting subcontracting to advisory medical practitioners only. Health care professionals such as physical and occupational therapists should also be allowed to perform the initial reviews and issue approvals.

Response: The rule for subcontracting will be amended so that utilization review agents may subcontract with registered nurses, who are allowed to approve recommended treatments. As for physical and occupational therapists, such professionals have a limited scope of practice. See Tenn. Comp. R. & Regs. 1150-01. As such, physicians and registered nurses are better-suited for the functions of a utilization review agent.

34) Comment: All recommended treatments that require utilization review should be listed in the chapter.

Response: The treatments requiring utilization review are contained in T.C.A. § 50-6-124 and in the Division's Medical Cost Containment Program, Medical Fee Schedule, and In-Patient Hospital Fee Schedule rules contained in Chapters 0800-02-17, 0800-02-18, and 0800-02-19, respectively. These provisions are easily accessible and any subsequent amendments to such provisions would cause a conflict with this Chapter. Accordingly, the Division declines to specifically list the treatments in this Chapter.

### Regulatory Flexibility Addendum

Pursuant to Public Chapter 464 of the 105<sup>th</sup> General Assembly, prior to initiating the rule making process as described in § 4-5-202(a)(3) and § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

(If applicable, insert Regulatory Flexibility Addendum here)

1. The type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, or directly benefit from the proposed rule: Utilization Review Agents, Insurance Carriers, Third Party Administrators, Hospitals, Ambulatory Surgical Treatment Centers, Rehabilitation Treatment Facilities, Non-Residential Treatment Facilities, Home Health Services, Physicians' Practices and Outpatient Diagnostic Centers, as well as any other health care providers extending services to injured employees under the Tennessee Workers' Compensation Act. The rules will provide for a more efficient utilization review system that should help injured employees reach maximum medical improvement sooner, which will decrease the need for temporary benefits and allow for quicker settlements.
2. The projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record: The employer (or its insurer or third party administrator), utilization review agent, and medical provider will need to share information among themselves and with the employee and Division, when necessary. The reporting and information sharing is an indispensable aspect of the utilization review process. The amended rules do allow for electronic transmissions and electronic imaging of records, which should alleviate the administrative costs to some extent. These entities should already have skilled staff to deal with records and reporting requirements.
3. A statement of the probable effect on impacted small businesses and consumers: The amended rules provide for a clearer and more efficient utilization review system. While several aspects of the amended rules are more onerous than the current rules, the overall impact of the new rules should result in more efficient medical care to injured employees, which will accelerate their achievement of maximum medical improvement. Accordingly, employers, and their insurers, will spend less in temporary disability benefits and will be able to settle cases more quickly.
4. A description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and objectives of the proposed rule that may exist, and to what extent the alternative means might be less burdensome to small business: The current utilization review system is inefficient and ineffective. The amended rules will place greater restrictions and responsibilities on the parties, but such is necessary to achieve the purposes and objectives of the amended rules. The Division has worked closely with the medical, legal, employee, employer, and insurance communities to make sure that the amended rules are workable and will achieve the goal of a more efficient and effective system.
5. Comparison of the proposed rule with any federal or state counterparts: The individuals and organizations affected by these rules will also be able to comply with T.C.A. § 56-6-701, et seq., which applies to all utilization reviews, not just workers' compensation. While these amended rules are stricter in several ways than T.C.A. §§ 56-6-701, et seq., the rules do not conflict with those statutes, but merely add requirements for utilization reviews performed in workers' compensation cases.
6. Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule: Any exemption from the requirements in the amended rules would thwart the purposes and objectives of the rules. Medical care to injured employees should be held to uniform standards throughout Tennessee so that every injured employee receives the best care available.

**Additional Information Required by Joint Government Operations Committee**

All agencies, upon filing a rule, must also submit the following pursuant to TCA 4-5-226(i)(1).

- (A)** A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

The amended rules are an overhaul of the utilization review system for workers' compensation injuries. After hearing a myriad of complaints about the current system, the Division worked closely with the medical, legal, employee, employer, and insurance communities to fix the system. The Division gave consideration to input from all of these interest groups. Accordingly, these amended rules streamline the utilization review process by adding requirements as to timeframes, reporting, and qualifications for those operating under these rules.

- (B)** A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

T.C.A. § 50-6-124 requires the Commissioner of Labor and Workforce Development to establish a system of utilization review for workers' compensation claims and T.C.A. § 50-6-233 gives the Commissioner the authority to implement rules and regulations.

- (C)** Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

Utilization Review Agents, Insurance Carriers, Third Party Administrators, Hospitals, Ambulatory Surgical Treatment Centers, Rehabilitation Treatment Facilities, Non-Residential Treatment Facilities, Home Health Services, Physicians' Practices and Outpatient Diagnostic Centers, as well as any other health care providers extending services to injured employees under the Tennessee Workers' Compensation Act. The medical and legal communities have applauded the amended rules. The insurance and utilization review agent communities have concerns about the new requirements and any additional costs that may be involved, but have not provided any empirical evidence that the amended rules will add significant costs or that any purported costs will outweigh the benefit of a more efficient system.

- (D)** Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

The Division is unaware of any opinions or rulings that directly relate to the rules, except that the Tennessee Supreme Court has previously ruled that courts have jurisdiction to hear utilization review appeals. See *Kilgore v. NHC Healthcare*, 134 S.W.3d 153 (Tenn. 2004).

- (E)** An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

The Division will be handling appeals of utilization review denials when requested by the employee or treating physician. The Division currently performs this function, but the amended rules do allow the Division the option of implementing fees for the appeals to be paid by the employer, or its insurer. It is not expected that these fees will result in significant revenue.

- (F)** Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Landon Lackey, attorney for the Division of Workers' Compensation

- (G)** Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Landon Lackey, attorney for the Division of Workers' Compensation

- (H)** Office address and telephone number of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

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Nashville, TN 37243  
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- (I)** Any additional information relevant to the rule proposed for continuation that the committee requests.

None.