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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. T.C.A. § 4-5-205*

<b>Agency/Board/Commission:</b>	Department of Labor & Workforce Development
<b>Division:</b>	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 to accommodate multiple chapters. Please enter only ONE Rule Number/Rule Title 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-.06	Time Requirements
0800-02-06-.07	Appeals of Utilization Review Decisions
0800-02-06-.10	Sanctions and Civil Penalties
0800-02-06-.12	Appeals for Pain Management Services

Chapter Number	Chapter Title
0800-02-07	General Rules of the Workers' Compensation Program – Case Management
Rule Number	Rule Title
0800-02-07-.01	Definitions
0800-02-07-.02	Case Management System
0800-02-07-.04	Elements of Case Management
0800-02-07-.06	Confidentiality of Records

Chapter Number	Chapter Title
0800-02-17	Medical Cost Containment Program
Rule Number	Rule Title
0800-02-17-.01	Purpose and Scope
0800-02-17-.03	Definitions
0800-02-17-.05	Procedure Codes/Adoption of the CMS' Medicare Procedures, Guidelines and Amounts

0800-02-17-.12	Recovery of Payment
0800-02-17-.13	Penalties for Violations of Fee Schedule Rules
0800-02-17-.21	Process for Resolving Differences Between Carriers and Providers Regarding Bills
0800-02-17-.22	Administrative Review of Fee Schedule Disputes/Hearings
0800-02-17-.23	Rule Review
0800-02-17-.25	Impairment Ratings – Evaluations and in Medical Records

<b>Chapter Number</b>	<b>Chapter Title</b>
0800-02-18	Medical Fee Schedule
<b>Rule Number</b>	<b>Rule Title</b>
0800-02-18-.02	General Information and Instructions for Use
0800-02-18-.12	Pharmacy Schedule Guidelines
0800-02-18-.15	Penalties for Violations of Fee Schedules

<b>Chapter Number</b>	<b>Chapter Title</b>
0800-02-19	In-Patient Hospital Fee Schedule
<b>Rule Number</b>	<b>Rule Title</b>
0800-02-19-.02	Definitions
0800-02-19-.06	Penalties for Violations of Fee Schedules

<b>Chapter Number</b>	<b>Chapter Title</b>
0800-02-20	Medical Impairment Rating Registry Program
<b>Rule Number</b>	<b>Rule Title</b>
0800-02-20-.01	Definitions
0800-02-20-.04	Requisite Physician Qualifications for Inclusion on Medical Impairment Rating Registry
0800-02-20-.05	Application Procedures for Physicians to Join the Registry
0800-02-20-.06	Requests for a MIR Registry Physician
0800-02-20-.07	Payments/Fees
0800-02-20-.09	Communication with Registry Physicians
0800-02-20-.13	Removal of a Physician from the Registry
0800-02-20-.14	Penalties
0800-02-20-.15	Time Limits

(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

Amendments

Chapter 0800-02-06 General Rules of the Workers' Compensation Program – Utilization Review is amended by deleting all references to “Commissioner” that refer to the commissioner of the department of labor and workforce development and replacing such with “Administrator” in Rules 0800-02-06-.01(8) & (15), 0800-02-06-.02(3), 0800-02-06-.06(5)(b), and 0800-02-06-.10(1).

Authority: T.C.A. §§ 50-6-102, 50-6-124, 50-6-126, 50-6-233, and Public Chapters 282 & 289 (2013).

Rule 0800-02-06-.01 Definitions is amended by deleting subsections (7) and (22) and renumbering the remaining subsections accordingly.

Authority: T.C.A. §§ 50-6-102, 50-6-124, 50-6-126, 50-6-233, and Public Chapters 282 & 289 (2013).

Rule 0800-02-06-.07 Appeals of Utilization Review Decisions is amended by deleting subsection (2) in its entirety and replacing it with the following:

- (2) Upon receipt of an appeal request by an employee or authorized treating physician:
  - (a) The Division or its designated contractor shall conduct the utilization review appeal. The Division or its designated contractor may contact the authorized treating physician for peer review purposes. The Division or its designated contractor shall determine the medical necessity of the recommended treatment as soon as practicable after receipt of all necessary information. The Division or its designated contractor shall then transmit such determination to the authorized treating physician, employee, and employer. The determination of the Division or its designated contractor is final for administrative purposes, subject to the provisions of subsections (3)-(5) of this Rule.
  - (b) If any information necessary for the determination of the appeal is not within the possession of the Division, then any party withholding such information 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 Division 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 Division's completion of the appeal.

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).

Rule 0800-02-06-.12 Appeals for Pain Management Services is amended by deleting the section in its entirety.

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.

Chapter 0800-02-07  
General Rules of the Workers' Compensation Program  
Case Management

Amendments

Chapter 0800-02-07 General Rules of the Workers' Compensation Program – Case Management is amended by deleting all references to “Commissioner” that refer to the commissioner of the department of labor and workforce

development and replacing such with "Administrator" in Rules 0800-02-07-.01(6), 0800-02-07-.02(2), 0800-02-07-.04(2)(c), and 0800-02-07-.06(1).

Authority: T.C.A. §§ 50-6-102, 50-6-123, 50-6-126, 50-6-233, and Public Chapters 282 & 289 (2013).

Rule 0800-02-07-.01 Definitions – General is amended by deleting the language in subsection (4) and replacing it with the following:

- (4) "Administrator" means the Administrator of the Division of Workers' Compensation of the Department of Labor and Workforce Development, or the Administrator's designee.

Authority: T.C.A. §§ 50-6-102, 50-6-123, 50-6-126, 50-6-233, and Public Chapters 282 & 289 (2013).

Chapter 0800-02-17  
Medical Cost Containment Program

Amendments

Chapter 0800-02-17 Medical Cost Containment Program is amended by deleting all references to "Commissioner" that refer to the commissioner of the department of labor and workforce development and replacing such with "Administrator" in Rules 0800-02-17-.01(1) & (2)(c), 0800-02-17-.03(4), (36), (42), (47), (61), (76) & (77), 0800-02-17-.05(4), 0800-02-17-.13(1) & (4), 0800-02-17-.23, and 0800-02-17-.25(4) & (6).

Authority: T.C.A. §§ 50-6-102, 50-6-204, 50-6-205, 50-6-226, 50-6-233, and Public Chapters 282 & 289 (2013).

Rule 0800-02-17-.03 Definitions is amended in subsection (3) by adding the phrase "or the Administrator's designee" at the end.

Authority: T.C.A. §§ 50-6-102, 50-6-204, 50-6-233, and Public Chapters 282 & 289 (2013).

Rule 0800-02-17-.12 Recovery of Payment is amended in subsection (1) by deleting the last sentence in the subsection and is further amended by deleting subsections (2)-(6).

Authority: T.C.A. §§ 50-6-204, 50-6-205, 50-6-226 and 50-6-233.

Rule 0800-02-17-.21 Process for Resolving Differences Between Carriers and Providers Regarding Bills is amended by deleting the section in its entirety and replacing it with the following:

- (1) Disputes
- (a) Unresolved disputes between a carrier and provider concerning bills due to conflicting interpretation of these Rules and/or the Medical Fee Schedule Rules and/or the In-patient Hospital Fee Schedule Rules may be presented to the Medical Payment Committee (or "Committee") on or after July 1, 2014. A request for Committee Review may be submitted within one (1) year of the date of service to: Medical Director of the Workers' Compensation Division, Tennessee Department of Labor and Workforce Development, 220 French Landing Drive, Nashville, Tennessee 37243, or any subsequent address as prescribed by the Division.
- (b) Valid requests for Committee Review must be accompanied by a form prescribed by the Division, must be legible and complete, and must contain copies of the following:
1. Copies of the original and resubmitted bills in dispute which include dates of service, procedure codes, bills for services rendered and any payment received, and an explanation of unusual services or circumstances;
  2. Copies of all explanations of benefit (EOB's);

3. Supporting documentation and correspondence, if any;
  4. Specific information regarding contact with the carriers; and
  5. A verified or declared written medical report signed by the physician and all pertinent medical records.
- (c) The party requesting Committee Review must send a copy of the request and all documentation accompanying the request to the opposing party at the same time it is submitted to the Medical Director.
- (d) If the request for review does not contain proper documentation, then the Committee will decline to review the dispute. Likewise, if the timeframe in this Rule is not met, then the Committee will decline to review the dispute, but such failure shall not provide an independent basis for denying payment or recovery of payment.

Authority: T.C.A. §§ 50-6-126, 50-6-204, 50-6-205, 50-6-226, 50-6-233, and Public Chapters 282 & 289 (2013).

Rule 0800-02-17-.22 Administrative Review of Fee Schedule Disputes/Hearings is amended by changing the title of the rule to "Committee Review of Fee Schedule Disputes/Hearings" and is further amended deleting subsection (1) in its entirety and replacing it with the following:

(1) Committee Review Procedure

- (a) When a valid request for Committee Review is received by the Division's Medical Director, the parties will be notified when the Committee will consider the dispute. The Committee may consider the dispute at any meeting during which it has a quorum of the voting members. Members may participate by telephone or by video conferencing and members who participate by telephone or video conferencing shall be counted as if physically present for purposes of establishing a quorum.
- (b) The parties will have the opportunity to submit documentary evidence and present arguments to the Committee prior to and during the Committee meeting in which the dispute will be heard.
- (c) The Committee shall consider the dispute and issue its decision as to the proper resolution of the dispute. If the dispute is not ripe for a decision, then the Committee may continue it to the next meeting.
- (d) If the parties to the dispute do not follow the decision of the Committee, then either party may proceed in any court of law with proper jurisdiction to decide the dispute.

Authority: T.C.A. §§ 50-6-204, 50-6-205, 50-6-233, and Public Chapters 282 & 289 (2013).

Rule 0800-02-17-.23 Rule Review is amended by deleting the reference to "Medical Care and Cost Containment Committee" and replacing it with "Medical Payment Committee."

Authority: T.C.A. §§ 50-6-204 and Public Chapters 282 & 289 (2013).

Chapter 0800-02-18  
Medical Fee Schedule

Amendments

Chapter 0800-02-18 Medical Fee Schedule is amended by deleting all references to "Commissioner" that refer to the commissioner of the department of labor and workforce development and replacing such with "Administrator" in Rules 0800-02-18-.02(2)(b) & (6)(a), 0800-02-18-.12(1)(e)(1), and 0800-02-18-.15(1) & (4).

Authority: T.C.A. §§ 50-6-102, 50-6-6-204, 50-6-205, 50-6-226, 50-6-233, and Public Chapters 282 & 289 (2013).

Chapter 0800-02-19  
In-Patient Hospital Fee Schedule

Amendments

Chapter 0800-02-19 In-Patient Hospital Fee Schedule is amended by deleting all references to "Commissioner" that refer to the commissioner of the department of labor and workforce development and replacing such with "Administrator" in Rules 0800-02-19-.02(2) and 0800-02-19-.06(1) & (5).

Authority: T.C.A. §§ 50-6-102, 50-6-125, 50-6-128, 50-6-6-204, 50-6-205, 50-6-233, and Public Chapters 282 & 289 (2013).

Rule 0800-02-19-.02 Definitions is amended in subsection (1) by adding the phrase "or the Administrator's designee" at the end.

Authority: T.C.A. §§ 50-6-125, 50-6-128, 50-6-204, 50-6-205, and Public Chapters 282 & 289 (2013).

Chapter 0800-02-20  
Medical Impairment Rating Registry Program

Amendments

Chapter 0800-02-20 Medical Impairment Rating Registry Program is amended by deleting all references to "Commissioner" that refer to the commissioner of the department of labor and workforce development and replacing such with "Administrator" in Rules 0800-02-20-.01(10), (12) & (13), 0800-02-20-.04(1)(b) & (c), 0800-02-20-.05(1), (2)(d), (e) & (k), & (3), 0800-02-20-.06(1), (3), (5), (7)(a) & (10)(d), 0800-02-20-.07(2) & (3), 0800-02-20-.09(1), 0800-02-20-.13(1)-(3), 0800-02-20-.14(4) & (5), and 0800-02-20-.15(1).

Authority: T.C.A. §§ 50-6-102, 50-6-6-204, 50-6-205, 50-6-233, and Public Chapters 282 & 289 (2013).

Rule 0800-02-19-.01 Definitions is amended in subsection (2) by adding the phrase "or the Administrator's designee" at the end.

Authority: T.C.A. §§ 4-5-202, 50-6-204, and Public Chapters 282 & 289 (2013).

\* 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 administrator (board/commission/ other authority) on 9/6/13 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 05/21/2013

Rulemaking Hearing(s) Conducted on: (add more dates). 07/09/13

Date: 9/6/13

Signature: Abbie Hudgens

Name of Officer: Abbie Hudgens

Title of Officer: Administrator of the Division of Workers' Compensation



Subscribed and sworn to before me on: 9/6/2013

Notary Public Signature: Darlene Carver-McDonald

My commission expires on: May 8, 2017

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

12-13-13

Date

**Department of State Use Only**

Filed with the Department of State on: 12/26/13

Effective on: 3/26/14

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.

Comment: The fee for utilization review appeals should contain a provision that would allow the Division to assess the fee against an employee or medical provider if it is determined that the appeal is frivolous.

Response: The Division agrees that there should be some way to disincentivize unwarranted appeals. The Division plans to address this concern, however, in the comprehensive re-write of the utilization review chapter, which will allow the Division and all stakeholders to comment on such a proposal and create a process for determining when an appeal is unwarranted. Accordingly, the comment is well-taken, but is better suited for a subsequent rulemaking hearing.

### Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

#### STATEMENT OF ECONOMIC IMPACT TO SMALL BUSINESSES

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: The amended rules will affect small employers that fall under the Tennessee Workers' Compensation Laws, which would be employers with at least five employees, or in the construction industry, at least one employee. The rule amendments are largely procedural and administrative in nature, except for the utilization review appeal fee, which is capped by statute at \$250.00.
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: Generally, employers' insurance carriers or third party administrators will be responsible for complying with the changes, so no administrative impact would be expected for small businesses.
3. A statement of the probable effect on impacted small businesses and consumers: Since these rule amendments are largely procedural and administrative, there would be no expected impact. To the extent the utilization review appeal fee has any impact, it would be expected to be very minimal because the fee is capped at \$250.00, whereas the average medical costs in a workers' compensation claim with a permanent impairment are \$21,864.11 (2011 data). As such, the fee would account for a very small percentage of the average claim and would fund a process that is intended to contain medical costs.
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: There are no less burdensome methods to achieve the purposes and objectives of the amended rule.
5. Comparison of the proposed rule with any federal or state counterparts: None.
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: It would be detrimental to small businesses that fall under the Tennessee Workers' Compensation Laws to be exempt from these rules because they are intended to contain medical costs.

## **Impact on Local Governments**

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 “any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments.” (See Public Chapter Number 1070 (<http://state.tn.us/sos/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

Local governments have the option to accept the provisions of the workers' compensation laws pursuant to T.C.A. § 50-6-106(6), but are not required to do so. For those local governments that do accept the provisions of the workers' compensation laws, the impact of the rule amendments will be minimal.

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

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 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 rule amendments reflect changes in the Division pursuant to the recently passed workers compensation reform act. See Public Chapters 282 and 289 (2013). These rule amendments are largely procedural and administrative in nature, except for the utilization review appeal fee, which is capped by statute.

- (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;

As noted above, Public Chapters 282 and 289 made many statutory changes to the administrative structure of the Division and these rule amendments reflect those changes.

- (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;

Since the rule amendments are procedural and administrative in nature and are intended to synchronize the rules with the recently-passed statutes, there are no known groups urging adoption or rejection of the rule amendments.

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

None.

- (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;

Local governments have the option to accept the provisions of the workers' compensation laws pursuant to T.C.A. § 50-6-106(6), but are not required to do so. For those local governments that do accept the provisions of the workers' compensation laws, the impact of the rule amendments will be minimal. The state government is subject to some provisions of the workers' compensation laws, but not all, and will not be impacted by these rule amendments.

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

Landon Lackey, Benefit Review Director  
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, Benefit Review Director  
Division of Workers' Compensation

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

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**(I)** Any additional information relevant to the rule proposed for continuation that the committee requests.

None.

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

**0800-02-06-.01 DEFINITIONS.**

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

~~(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 ~~Administrator~~ Commissioner has contracted to provide utilization review, including peer review, for the Division, as referred to in T.C.A. § 50-6-124.

(15) "Medical Director" means the Medical Director of the Division appointed by the ~~Administrator~~ Commissioner pursuant to T.C.A. § 50-6-126, or the Medical Director's designee chosen to act on behalf of the Medical Director.

~~(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.~~

**0800-02-06-.02 UTILIZATION REVIEW SYSTEM.**

(3) The ~~Administrator~~ 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.

**0800-02-06-.06 TIME REQUIREMENTS.**

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

(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 ~~Administrator~~ 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 ~~Administrator~~ Commissioner.

**0800-02-06-.07 APPEALS OF UTILIZATION REVIEW DECISIONS.**

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

(a) The Division or its designated contractor shall conduct the utilization review appeal. The Division or its designated contractor may contact the authorized treating physician for peer review

purposes. The Division or its designated contractor shall determine the medical necessity of the recommended treatment as soon as practicable within twenty-five (25) business days after receipt of all necessary information. The Division or its designated contractor shall then transmit such determination to the authorized treating physician, employee, and employer. The determination of the Division or its designated contractor is final for administrative purposes, subject to the provisions of subsections (3)-(5) of this Rule.

(b) If any information necessary for the determination of the appeal is not within the possession of the 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 Administrator Commissioner.

(c)  
~~(e) The Division shall charge a fee, 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 Division's completion of the appeal. 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~~

#### **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 Administrator 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.

#### **0800-02-06-.12 APPEALS FOR PAIN MANAGEMENT SERVICES.**

~~The Division shall charge a fee of no more than \$224.00 per utilization review appeal for any utilization review conducted pursuant to T.C.A. § 50-6-204(j). The fee shall be paid by the employer within 30 calendar days of the Division's completion of the appeal. If the fee is not paid within such timeframe, then a 10% interest payment shall accrue for every 30 calendar days that the fee remains unpaid.~~

### **General Rules of the Workers' Compensation Program – Case Management Chapter 0800-02-07**

#### **0800-2-7-.01 DEFINITIONS - GENERAL.**

As used in this chapter, the following terms are used as follows:

- (4) "~~Commissioner~~Administrator" means the Administrator Commissioner of the Division of Workers' Compensation of the Department of Labor and Workforce Development, or the Administrator's designee.
- (6) "Medical Director" means the Medical Director appointed by the Administrator Commissioner of Labor and Workforce Development pursuant to T.C.A. § 50-6-126.

#### **0800-2-7-.02 CASE MANAGEMENT SYSTEM.**

- (2) The ~~Commissioner-Administrator~~ shall provide or contract for certain case management services. The case management services which are provided or contracted for shall include, but not limited to, providing;

#### **0800-2-7-.04 ELEMENTS OF CASE MANAGEMENT.**

- (2)(c) The contractor shall report any instances of inappropriate case management services or inadequate supervision to the Medical Director. The Medical Director shall report any instance of failure to appropriately supervise a case manager assistant, negligence or other unprofessional or malpractice conduct by a case manager to the ~~Commissioner-Administrator~~ and to either the Board of Medical Examiners or the Board of Nursing for appropriate disciplinary proceedings.

#### **0800-2-7-.06 CONFIDENTIALITY OF RECORDS.**

- (1) Subject to any applicable requirement of law concerning confidentiality of records, a case manager or a firm providing case management services shall provide the ~~Commissioner-Administrator~~, or the ~~Commissioner's-Administrator's~~ designee, with any appropriate case management records or permit the ~~Commissioner-Administrator~~ or the ~~Administrator's-Commissioner's~~ designee to inspect, review, or copy such records in a responsible manner.

### **Medical Cost Containment Program Chapter 0800-02-17**

#### **0800-02-17-.01 PURPOSE AND SCOPE.**

- (1) Purpose. Pursuant to Tenn. Code Ann. § 50-6-204 (Repl. 2005), the following Medical Cost Containment Program Rules, together with the Medical Fee Schedule Rules, Chapter 0800-02-18-.01 et seq., and the In-patient Hospital Fee Schedule Rules, Chapter 0800-02-19-.01 et seq., (collectively hereinafter "Rules") are hereby adopted by the ~~Administrator-Commissioner~~ in order to establish a comprehensive medical fee schedule and a related system which includes, but is not limited to, procedures for review of bills, enforcement procedures and appeal hearings, to implement a medical fee schedule. The ~~Administrator-Commissioner~~ promulgates these Rules to establish the maximum allowable fees for health care services falling within the purview of the Tennessee Workers' Compensation Act ("Act"). These Medical Cost Containment Program Rules must be used in conjunction with the Medical Fee Schedule Rules and the In-patient Hospital Fee Schedule Rules. The Rules establish maximum allowable fees and procedures for all medical care and services provided to any employee claiming medical benefits under the Tennessee Workers' Compensation Act. Employers, carriers and providers may negotiate and contract or pay lesser fees as are agreeable between them, but in no event shall reimbursement be in excess of the Rules, subject to the civil penalties prescribed in the Rules, as assessed by, and in the discretion of, the ~~Administrator-Commissioner~~, the ~~Administrator's-Commissioner's~~ designee, or an agency member appointed by the ~~Administrator-Commissioner~~. These Rules are applicable only to those injured employees claiming benefits under the Tennessee Workers' Compensation Act, but are applicable in any state in which that employee seeks such medical benefits.

- (2) These rules do all of the following:

(c) Establish procedures by which a health care provider shall be paid the lesser of: (1) the provider's usual bill, (2) the maximum fee established under these Rules, or (3) the MCO/PPO or any other negotiated and contracted or lower price, where applicable. In no event shall reimbursement be in excess of these Rules. Reimbursement in excess of these Rules may, at the ~~Administrator's-Commissioner's~~ discretion, result in civil penalties of up to ten thousand dollars (\$10,000.00) per violation each assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, if a pattern or practice of such activity is found.

At the ~~Administrator's Commissioner's~~ discretion, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Act.

#### 0800-02-17-.03 DEFINITIONS.

- (3) "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.~~
- (4) "Appropriate care" means health care that is suitable for a particular person, condition, occasion, or place as determined by the ~~Administrator Commissioner~~ or the ~~Administrator Commissioner's~~ designee after consultation with the Medical Director.
- (36) "Inappropriate health care" means health care that is not suitable for a particular person, condition, occasion, or place as determined by the ~~Administrator Commissioner~~ or the ~~Administrator's Commissioner's~~ designee after consultation with the Division's Medical Director.
- (42) "Maximum allowable payment" means the maximum fee for a procedure established by these Rules or the usual and customary bill as defined in these Rules, whichever is less, except as otherwise might be specified. In no event shall reimbursement be in excess of the Division's Medical Fee Schedule. Bills in excess of the Division's Medical Fee Schedule shall, at the ~~Administrator's Commissioner's~~ discretion, result in civil penalties of up to ten thousand dollars (\$10,000.00) per violation for each violation assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, whenever a pattern or practice of such activity is found. At the ~~Administrator's Commissioner's~~ discretion, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Act.
- (47) "Medical Director" means the Division's Medical Director appointed by the ~~Administrator Commissioner~~ pursuant to T.C.A. § 50-6-126 (Repl. 1999).
- (61) "Pattern or practice" means at least one (1) or more violations of the Medical Fee Schedule Rules, the Medical Cost Containment Rules (Chapter 0800-02-17) and/or the In-patient Hospital Fee Schedule Rules (Chapter 0800-02-19), have occurred after notice of a violation has issued from the ~~Division Department~~ for the first violation. To support civil penalties, such violations must be found to not have been inadvertent, as determined by the ~~Administrator Commissioner.~~
- (76) "Stop-Loss Reimbursement Factor" or "SLRF" means a factor established by the ~~Administrator Commissioner~~ to be used as a multiplier to establish a reimbursement amount when total hospital bills have exceeded specific stop-loss thresholds.
- (77) "Stop-Loss Threshold" or "SLT" means a threshold of bills established by the ~~Administrator Commissioner,~~ beyond which reimbursement is calculated by multiplying the applicable SLRF times the total bills identifying that particular threshold.

#### 0800-02-17-.05 PROCEDURE CODES/ADOPTION OF THE CMS' MEDICARE PROCEDURES, GUIDELINES AND AMOUNTS.

- (4) Whenever there is no specific fee or methodology for reimbursement set forth in these Rules, then the maximum amount of reimbursement shall be at 100% of the current, effective CMS' Medicare allowable amount. The most current effective Medicare guidelines and procedures shall be followed in arriving at the correct amount, subject to the requirements of Rule 0800-02-18-.02(4). The conversion amounts may, upon review by the ~~Administrator Commissioner,~~ be adjusted annually. Whenever there is no applicable Medicare code or methodology, the service,

equipment, diagnostic procedure, etc. shall be reimbursed at the usual and customary amount as defined in Rule 0800-02-17-.03(80) of this Chapter.

#### **0800-02-17-.12 RECOVERY OF PAYMENT.**

- (1) Nothing in these Rules shall preclude the recovery of payment already made for services and bills which may later be found to have been medically paid at an amount which exceeds the maximum allowable payment. Likewise, nothing in these Rules shall preclude any provider from receiving additional payment for services or supplies if it is properly due that provider and does not exceed the amount allowed by these Rules. ~~If the timeframes in these Rules are not met, then the Medical Care and Cost Containment Committee will decline to review the dispute, but such failure shall not provide an independent basis for denying payment or recovery of payment.~~
- (2) ~~A carrier may recover a payment to a provider, whether by an employee or a carrier, if the carrier requests the provider for the recovery of the payment, with a statement of reasons for the request, within one year of the date of payment. A provider may likewise recover additional payment from any carrier with a statement of reasons for the request, within one year of the date of service.~~
- (3) ~~Within thirty-one (31) calendar days of receipt of the carrier's or provider's request for recovery of the payment, the provider or carrier shall do either of the following:~~
  - (a) ~~If in agreement with the request, the provider shall refund payment to the carrier, or in the case of a provider requesting additional payment, the carrier shall submit payment to the provider;~~
  - (b) ~~If not in agreement with the request, supply the carrier or provider with a written detailed statement of the reasons for the disagreement, along with a refund of the portion, if any, of the payment that the provider agrees should be refunded, or payment of the amount the carrier agrees should be paid to the provider.~~
- (4) ~~If the carrier or provider does not accept the reason for disagreement supplied by the adverse party, the carrier or provider may file a request for Administrative Review, within thirty-one (31) calendar days of receipt of the provider's statement of disagreement. The request for review shall be filed with the Medical Director for a recommendation by the Medical Care and Cost Containment Committee ("MCCCC"). The complaining party shall supply a copy to the opposing party.~~
- (5) ~~If, within 62 calendar days of the provider or carrier's request for recovery of a payment, the carrier or provider does not receive either a full refund of the payment (or full payment in the case of providers) or a statement of disagreement, then, at the option of the carrier or provider, the carrier or provider may do the following:~~
  - (a) ~~File a request for Administrative Review as outlined above, of which the complaining party shall supply a copy to the opposing party.~~
  - (b) ~~If a carrier, then reduce the payable amount on the provider's subsequent bills (in the case in question or any other case) to the extent of the request for recovery of payment.~~
- (6) ~~If, within thirty-one (31) calendar days of a recommendation from the MCCCC, the amount recommended is not paid, the carrier may reduce the payable amount on the provider's subsequent bills to the extent of the request for recovery of payment, plus an additional 25% per annum. A provider may also add the additional 25% per annum to the amount recommended to be paid by the MCCC. The provider or carrier may, at its discretion, pursue recovery of the refund or, in the case of providers, additional payment, in a court of law with proper jurisdiction pursuant to Tenn. Code Ann. § 50-6-226.~~

#### 0800-02-17-.13 PENALTIES FOR VIOLATIONS OF FEE SCHEDULE RULES.

- (1) Providers shall not accept and employers or carriers shall not pay any amount for health care services provided for the treatment of a covered injury or illness or for any other services encompassed within the Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, when that amount exceeds the maximum allowable payment established by these Rules. Any provider accepting and any employer or carrier paying an amount in excess of the Division's Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, shall be in violation of these Rules and may, at the ~~Administrator's~~ ~~Commissioner's~~ discretion, be subject to civil penalties of up to ten thousand dollars (\$10,000.00) per violation for each violation, which may be assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, whenever a pattern or practice of such activity is found. Any provider reimbursed or carrier paying an amount which is in excess of these Rules shall have a period of ninety (90) calendar days from the time of receipt/payment of such excessive payment in which to refund/recover the overpayment amount. Overpayments refunded/recovered within this time period shall not constitute a violation under these Rules. At the discretion of the ~~Administrator~~ ~~Commissioner~~, the ~~Administrator's~~ ~~Commissioner's~~ Designee, or an agency member appointed by the ~~Administrator~~ ~~Commissioner~~, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Act. Any other violation of the Medical Cost Containment Program Rules, Medical Fee Schedule Rules, or the In-patient Hospital Fee Schedule Rules shall subject the violator(s) to a civil penalty of not less than one hundred dollars (\$100.00) nor more than ten thousand dollars (\$10,000.00) per violation, at the discretion of the ~~Administrator~~ ~~Commissioner~~, ~~Administrator's~~ ~~Commissioner's~~ Designee, or an agency member appointed by the ~~Administrator~~ ~~Commissioner~~.
- (4) Any request for a hearing shall be filed with the Division within fifteen (15) calendar days of the date of issuance of the Notice of Violation and, if applicable, of civil penalty. Failure to file a request for a hearing within fifteen (15) calendar days of the date of issuance of the Notice of Violation shall result in the decision of the ~~Administrator~~ ~~Commissioner~~, ~~Administrator's~~ ~~Commissioner's~~ Designee, or an agency member appointed by the ~~Administrator~~ ~~Commissioner~~ becoming a final order and not subject to further review.

#### 0800-02-17-.21 PROCESS FOR RESOLVING DIFFERENCES BETWEEN CARRIERS AND PROVIDERS REGARDING BILLS.

##### ~~(1) Carrier's Dispute of a Bill~~

~~(a) When a carrier adjusts and/or disputes a bill or portion thereof, the carrier shall notify the provider within thirty one (31) calendar days of the receipt of the bill of the specific reasons for adjusting and/or disputing the bill or portion thereof, and shall notify the provider of its right to provide additional information and to request reconsideration of the carrier's action.~~

~~(b) If the provider sends a bill to a carrier and the carrier does not respond in thirty one (31) calendar days, and if a provider sends a second bill and receives no response within 62 calendar days from the date the provider supplied the first bill, the provider may then proceed with whatever collection actions it deems appropriate in a court of law with proper jurisdiction.~~

~~(c) The carrier shall notify the employer, employee and the provider that the rules prohibit a provider from billing an employee, employer, or carrier for any amount for health care services provided for the treatment of a compensable work-related injury, illness or occupational disease when that amount is disputed by the carrier pursuant to its utilization review program, or when the amount exceeds the maximum allowable payment established by the Fee Schedule Rules~~

~~(Medical and In-patient Hospital). The carrier shall request the employee to notify the carrier if the provider so bills the employee, or employer.~~

~~(2) Provider's Request for Reconsideration of Bill~~

~~A provider may request reconsideration of its adjusted and/or disputed bill by a carrier within thirty-one (31) calendar days of receipt of a notice of an adjusted and/or disputed bill or portion thereof. The provider's request to the carrier for reconsideration of the adjusted and/or disputed bill shall include a statement in detail of the reasons for disagreement with the carrier's adjustment and/or dispute of a bill or portion thereof.~~

~~(3) Carrier's Response to Provider's Request for Reconsideration of Bill; Provider's Right to Appeal:~~

~~(a) Within thirty-one (31) calendar days of receipt of a provider's request for reconsideration, the carrier shall notify the provider of the actions taken and a detailed statement of the reasons. The carrier's notification shall include an explanation of the appeal process provided under this rule.~~

~~(b) If a provider disagrees with the action taken by the carrier on its request for reconsideration, the provider may file a request for Administrative Review within thirty-one (31) calendar days from the date of receipt of a carrier's denial of the provider's request for reconsideration, and the provider shall supply a copy to the carrier.~~

~~(c) If within sixty-two (62) calendar days of the provider's request for reconsideration, the provider does not receive payment for the adjusted and/or disputed bill or portion thereof, or a written detailed statement of the reasons for the actions taken by the carrier, then the provider may make application for Administrative Review by the MCCCC.~~

~~(14) Disputes~~

~~(a) Unresolved disputes between a carrier and provider concerning bills and/or due to conflicting interpretation of these Rules and/or the Medical Fee Schedule Rules and/or the In-patient Hospital Fee Schedule Rules may be presented to the Medical Care and Cost Containment Payment Committee (or "Committee") on or after July 1, 2014. A request for Committee Administrative Review may be submitted within one (1) year of the date of service to: Medical Director of the Workers' Compensation Division, Tennessee Department of Labor and Workforce Development, 220 French Landing Drive, Nashville, Tennessee 37243, or any subsequent address as prescribed by the Division.~~

~~(b) Valid requests for Committee Administrative Review must be accompanied by a form prescribed by the Division, must be legible, and must contain copies of the following:~~

- ~~1. Copies of the original and resubmitted bills in dispute which include dates of service, procedure codes, bills for services rendered and any payment received, and an explanation of unusual services or circumstances;~~
- ~~2. Copies of the specific reimbursement all explanations of benefits (EOB's);~~
- ~~3. Supporting documentation and correspondence, if any;~~
- ~~4. Specific information regarding contact with the carriers; and.~~
- ~~5. A verified or declared written medical report signed by the physician and all pertinent medical records.~~
- ~~6. A specific written request for Administrative Review.~~

(c) The party requesting Administrative Committee Review must send a copy of the request and all documentation accompanying the request to the opposing party at the same time it is submitted to the Medical Director.

(d) If the request for review does not contain proper documentation, then the MCCCG Committee will decline to review the dispute. Likewise, if the timeframes in this Rule is are not met, then the MCCCG Committee will decline to review the dispute, but such failure shall not provide an independent basis for denying payment or recovery of payment.

#### **0800-02-17-.22 ADMINISTRATIVE COMMITTEE REVIEW OFFEE SCHEDULE DISPUTES/HEARINGS.**

##### **(1) Administrative Committee Review Procedure**

(a) When a valid request for Administrative Committee Review by the MCCCG is received by the Division's Medical Director, the parties will be notified when the MCCCG Committee will consider the dispute. The Committee may consider the dispute at any meeting during which it has a quorum of the voting members. Members may participate by telephone or by video conferencing and members who participate by telephone or video conferencing shall be counted as if physically present for purposes of establishing a quorum

(b) The parties will have the opportunity to submit documentary evidence and present arguments to the Committee prior to and during the Committee meeting in which the dispute will be heard. The MCCCG shall consider the dispute and issue its recommendation as to the proper resolution of the dispute.

(c) The Committee shall consider the dispute and issue its decision as to the proper resolution of the dispute. If the dispute is not ripe for a decision, then the Committee may continue it to the next meeting. If the parties to the dispute do not follow the recommendation of the MCCCG, then either party may proceed in any court of law with proper jurisdiction to decide the dispute.

(d) If the parties to the dispute do not follow the decision of the Committee, then either party may proceed in any court of law with proper jurisdiction to decide the dispute.

#### **0800-02-17-.23 RULE REVIEW.**

The Division encourages participation in the development of and changes to the Medical Cost Containment Program Rules, the Medical Fee Schedule Rules and the In-patient Hospital Fee Schedule Rules by all groups, associations, and the public. Any such group, association or other party desiring input into or changes made to these Rules and associated schedules must make their recommendations, in writing, to the Administrator Commissioner. After analysis, the Division may incorporate such recommended changes into Rules after appropriate consideration, public comment and compliance with the Uniform Administrative Procedures Act regarding promulgation of rules. The Medical Fee Schedule Rules, Medical Cost Containment Program Rules and In-Patient Hospital Fee Schedule Rules shall be reviewed by the Administrator Commissioner, in consultation with the Medical Care and Cost Containment Payment Committee and the Advisory Council on Workers' Compensation, on an annual basis. When appropriate, the Administrator Commissioner may revise these Rules as necessary and appropriate.

#### **0800-02-17-.25 IMPAIRMENT RATINGS-EVALUATIONS AND IN MEDICAL RECORDS.**

(4) Within twenty-one (21) calendar days of the date the treating physician determines the employee has reached maximum medical improvement, the treating physician shall submit to the employer or carrier, as applicable, a fully completed report on a form prescribed by the Administrator Commissioner. The employer or carrier, as applicable, shall submit a fully

completed form to the Division and the parties within thirty (30) calendar days of the date the treating physician determines the employee has reached maximum medical improvement.

- (6) The treating physician is required and responsible for providing the impairment rating, fully completing the report on a form prescribed by the ~~Administrator~~ ~~Commissioner~~, and submitting the report to the employer or carrier, as applicable, as required by these Rules. Notwithstanding Rule 0800-02-17-.15, the treating physician shall receive payment of no more than \$250.00 for these services to be paid by the employer or carrier. The payment shall only be made to the treating physician. The treating physician shall not require prepayment of such fee.

### Medical Fee Schedule Chapter 0800-02-18

#### 0800-02-18-.02 GENERAL INFORMATION AND INSTRUCTIONS FOR USE.

##### (2) Reimbursement

(b) Reimbursement to all providers shall be the lesser of the following:

4. In no event shall reimbursement be in excess of these TDWC Fee Schedule Rules, unless otherwise provided in the Division's rules. Reimbursement in excess of the TDWC Medical Fee Schedule Rules may result in civil penalties, at the ~~Administrator's~~ ~~Commissioner's~~ discretion, of up to \$10,000.00 per violation for each violation assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, should a pattern or practice of such activity be found. It is recognized that providers must bill all payers at the same amount and simply billing an amount which exceeds the Fee Schedule Rules does not constitute a violation. It is acceptance and retention of an amount in excess of this Fee Schedule Rules for longer than ninety (90) calendar days that constitutes a violation by a provider. At the ~~Administrator's~~ ~~Commissioner's~~ discretion, such provider may also be reported to the appropriate certifying board or other appropriate authority, and may be subject to exclusion from participating further in providing care under the Tennessee Workers' Compensation Act ("Act").

##### (6) Violations of Fee Schedule Rules and Medical Cost Containment Rules

(a) The ~~Commissioner~~ ~~Administrator~~, ~~Administrator's~~ ~~Commissioner's~~ Designee, or an agency member appointed by the ~~Administrator~~ ~~Commissioner~~, shall have the authority to issue civil penalties up to and including \$10,000.00 per violation for violations of the Medical Fee Schedule Rules, In-patient Hospital Fee Schedule Rules or the Medical Cost Containment Program Rules ("Rules") as prescribed in the Rules. Any party notified of an alleged violation, whether or not they are assessed civil penalties hereunder, shall be entitled to a contested case hearing before the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner pursuant to the Uniform Administrative Procedures Act, Tenn. Code Ann. § 4-5-101 et seq., if a written request is submitted to the Division by the party within fifteen (15) calendar days of issuance of notice of such violations and of any civil penalty. Failure to make a timely request will result in the violation and penalty decision becoming a final order and not subject to further review.

#### 0800-02-18-.12 PHARMACY SCHEDULE GUIDELINES.

##### (1) (e) Reimbursement

1. The pharmaceutical reimbursement formula for prescribed drugs (medicines by pharmacists and dispensing practitioners) is the lesser of:

(i) Average Wholesale Price\* ("AWP") + \$5.10 filling fee;

(ii) the provider's usual charge; or,

(iii) a negotiated contractual or other lesser amount.

\* The Administrator Commissioner may at any time adopt and implement a different base price other than AWP (such as average sales price), should medical reimbursement standards and/or local or other practices warrant, at the Administrator's Commissioner's discretion.

#### **0800-02-18-.15 PENALTIES FOR VIOLATIONS OF FEE SCHEDULES.**

(1) Providers shall not accept and employers or carriers shall not pay any amount for health care services provided for the treatment of a covered injury or illness or for any other services encompassed within the Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, when that amount exceeds the maximum allowable payment established by these Rules. Any provider accepting and any employer or carrier paying an amount in excess of the Division's Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, shall be in violation of these Rules and may, at the Administrator's Commissioner's discretion, be subject to civil penalties of up to ten thousand dollars (\$10,000.00) per violation for each violation, which may be assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, whenever a pattern or practice of such activity is found. Any provider reimbursed or carrier paying an amount which is in excess of these Rules shall have a period of ninety (90) calendar days from the time of receipt/payment of such excessive payment in which to refund/recover the overpayment amount. Overpayments refunded/recovered within this time period shall not constitute a violation under these Rules. At the discretion of the Administrator Commissioner, the Administrator's Commissioner's Designee, or an agency member appointed by the Administrator Commissioner, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Act. Any other violation of the Medical Cost Containment Program Rules, Medical Fee Schedule Rules, or the In-patient Hospital Fee Schedule Rules shall subject the violator(s) to a civil penalty of not less than one hundred dollars (\$100.00) nor more than ten thousand dollars (\$10,000.00) per violation, at the discretion of the Administrator Commissioner, Administrator's Commissioner's Designee, or an agency member appointed by the Administrator Commissioner.

(4) Any request for a hearing shall be filed with the Division within fifteen (15) calendar days of the date of issuance of the Notice of Violation and, if applicable, of civil penalty. Failure to file a request for a hearing within fifteen (15) calendar days of the date of issuance of the Notice of Violation shall result in the decision of the Administrator Commissioner, Administrator's Commissioner's Designee, or an agency member appointed by the Administrator Commissioner becoming a final order and not subject to further review.

#### **In-Patient Hospital Fee Schedule Chapter 0800-02-19**

#### **0800-02-19-.02 DEFINITIONS.**

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

(2) "Allowed Charges" or "Allowable Charges" shall mean charges reviewed and approved under

an appropriate audit and utilization review by the carrier as prescribed in the Division's Rules, or as determined by the Administrator Commissioner or the Administrator's Commissioner's designee after consultation with the Division's Medical Director.

#### **0800-02-19-.06 PENALTIES FOR VIOLATIONS OF FEE SCHEDULES.**

- (1) Providers shall not accept and employers or carriers shall not pay any amount for health care services provided for the treatment of a covered injury or illness or for any other services encompassed within the Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, when that amount exceeds the maximum allowable payment established by these Rules. Any provider accepting and any employer or carrier paying an amount in excess of the Division's Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, shall be in violation of these Rules and may, at the Administrator's Commissioner's discretion, be subject to civil penalties of up to ten thousand dollars (\$10,000.00) per violation for each violation, which may be assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, whenever a pattern or practice of such activity is found. Any provider reimbursed or carrier paying an amount which is in excess of these Rules shall have a period of ninety (90) calendar days from the time of receipt/payment of such excessive payment in which to refund/recover the overpayment amount. Overpayments refunded/recovered within this time period shall not constitute a violation under these Rules. At the discretion of the Administrator Commissioner, the Administrator's Commissioner's Designee, or an agency member appointed by the Administrator Commissioner, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Act. Any other violation of the Medical Cost Containment Program Rules, Medical Fee Schedule Rules, or the In-patient Hospital Fee Schedule Rules shall subject the violator(s) to a civil penalty of not less than one hundred dollars (\$100.00) nor more than ten thousand dollars (\$10,000.00) per violation, at the discretion of the Administrator Commissioner, Administrator's Commissioner's Designee, or an agency member appointed by the Administrator Commissioner.
- (5) Any request for a hearing shall be filed with the Division within fifteen (15) calendar days of the date of issuance of the Notice of Violation and, if applicable, of civil penalty. Failure to file a request for a hearing within fifteen (15) calendar days of the date of issuance of the Notice of Violation shall result in the decision of the Administrator Commissioner, Administrator's Commissioner's Designee, or an agency member appointed by the Administrator Commissioner becoming a final order and not subject to further review.

#### **Medical Impairment Rating Registry Program Chapter 0800-02-20**

**0800-02-20-.01 DEFINITIONS.** The following definitions are for the purposes of this chapter only:

- (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.
- (10) "Form" means the "Application for a Medical Impairment Rating," required to be used to request a MIR Registry physician from the Administrator Commissioner. The Form is available upon request from the Department or online at [www.state.tn.us/labor-wfd/mainforms.html](http://www.state.tn.us/labor-wfd/mainforms.html).
- (12) "Medical Director" means the Division's Medical Director, appointed by the Administrator Commissioner pursuant to T.C.A. § 50-6-126 (Repl. 1999) or the Medical Director's designee.

- (13) "Medical Impairment Rating Registry" or "MIR Registry" means the registry or listing of physicians established by the ~~Administrator Commissioner~~ pursuant to Tenn. Code Ann. § 50-6-204 (2005) to perform independent medical impairment ratings when there is a dispute as to the degree of medical impairment, as defined in 0800-02-20-.01(5) above.

**0800-02-20-.04 REQUISITE PHYSICIAN QUALIFICATIONS FOR INCLUSION ON MEDICAL IMPAIRMENT RATING REGISTRY.**

- (1) A physician seeking appointment to the MIR Registry shall make application and must satisfy the following qualifications:

(b) Be board-certified in his/her medical specialty by a board recognized by the American Board of Medical Specialties, the American Osteopathic Association or another organization acceptable to the ~~Administrator Commissioner~~;

(c) Have successfully completed a training course, approved by the ~~Administrator Commissioner~~, dedicated to the proper application of the applicable edition of the American Medical Association Guides to the Evaluation of Permanent Impairment (hereafter the "AMA Guides") in impairment evaluations and furnish satisfactory evidence thereof; and

**0800-02-20-.05 APPLICATION PROCEDURES FOR PHYSICIANS TO JOIN THE REGISTRY.**

- (1) Appointment to the MIR Registry shall expire upon a physician's decision to withdraw from the Registry or the Division's removal of a physician from the Registry. The Division reserves the right to charge physicians a non-refundable application fee upon appointment or reinstatement to the MIR Registry. For each application, an advisory panel of three (3) current MIR Registry physicians shall be randomly selected by the Program Coordinator to review the application. The Panel shall include one member from each grand division of the state who shall have been on the MIR Registry for at least five (5) years without any disciplinary actions imposed by the Department. Each member of the panel shall vote to either recommend or not recommend the applicant for inclusion on the MIR Registry. The ~~Administrator Commissioner~~, upon the advice of the Medical Director, Program Coordinator, and the advisory panel, shall have the sole and exclusive authority to approve or reject applications for inclusion on the MIR Registry.

- (2) Physicians seeking appointment to the MIR Registry shall complete an "Application for Appointment to the MIR Registry," available upon request or on-line at [www.state.tn.us/laborwfd/mainforms.html](http://www.state.tn.us/laborwfd/mainforms.html), certify to and, upon approval of the application, comply with the following conditions:

(d) While on the MIR Registry, agree to maintain an active and unrestricted license to practice medicine or osteopathy in Tennessee and to immediately notify the ~~Administrator Commissioner~~ of any change in the status of the license, including any restrictions placed upon the license;

(e) While on the MIR Registry, agree to maintain all board certifications listed on the application and to immediately notify the ~~Administrator Commissioner~~ of any change in their status;

(k) No later than fifteen (15) calendar days after a request by the Program Coordinator to refund to the paying party part or all of any fee paid by that party for a MIR Registry evaluation, as may be required by these Rules and the ~~Administrator Commissioner~~; and

- (3) Physicians denied appointment to the MIR Registry by the ~~Administrator Commissioner~~ or ~~Administrator's Commissioner's~~ designee on their initial application may seek reconsideration of their application by submitting a request for reconsideration stating the grounds for such reconsideration to the Program Coordinator within fifteen (15) calendar days of the issuance of the Notice of Denial of their application. The ~~Administrator Commissioner~~ may affirm or reverse the initial determination upon reconsideration of the initial decision. The

~~Administrator~~~~Commissioner~~ shall issue a Notice of Final Determination which shall be the final decision. If the ~~Administrator~~~~Commissioner~~ does not act on the request for reconsideration within twenty (20) calendar days, then the request shall be deemed to have been denied, which shall be the final decision.

#### **0800-02-20-.06 REQUESTS FOR A MIR REGISTRY PHYSICIAN.**

- (1) When a dispute of the degree of medical impairment, as defined in Rule 0800-02-20-.06 exists, any party may request a listing of physicians from the ~~Administrator's~~~~Commissioner's~~ MIR Registry by completing the "Application for Medical Impairment Rating" (hereinafter "Form"), available upon request from the Department or online at [www.state.tn.us/labor-wfd/mainforms.html](http://www.state.tn.us/labor-wfd/mainforms.html). The completed Form must then be returned to the Program Coordinator via electronic mail, facsimile or U.S. Mail.
- (3) The ~~Administrator~~~~Commissioner~~ requires the request for a MIR Registry physician designate:
- (5) If the parties cannot agree upon selection of a MIR Registry physician from the ~~Administrator's~~~~Commissioner's~~ listing of MIR Registry physicians provided within fifteen (15) calendar days of the Program Coordinator issuing the requested listing, it shall be the responsibility of the employer to provide a written request to the Program Coordinator to provide a three physician list by submitting such request on the Form. A written opinion as to the permanent impairment rating given by the MIR Registry physician selected pursuant to this Rule shall be presumed to be the accurate impairment rating.
- (7) The three (3) physician listing.
  - (a) Within five (5) business days of receipt of the completed "Application for a Medical Impairment Rating," the Division shall produce a list of three qualified physicians drawn from the ~~Administrator's~~~~Commissioner's~~ MIR Registry, from which one physician shall be designated to perform the evaluation. The three-physician listing created will be comprised of physicians qualified, based on the information provided by the physician and on their accreditation to perform evaluations of the body part(s) and/or medical condition(s) designated on the application for an evaluation. Psychiatric or psychological evaluations regarding mental and/or behavioral impairment shall be performed by a psychiatrist.
- (10) Submission of Medical Records.
  - (d) Medical bills, adjustor notes, surveillance tapes, denials, vocational rehabilitation reports, case manager records, commentaries, depositions, or any other document deemed by the ~~Administrator~~~~Commissioner~~ to compromise the impartiality of the review shall not be submitted to the MIR Registry physician.

#### **0800-02-20-.07 PAYMENTS/FEES.**

- (2) The evaluation fee includes normal record review, the evaluation, and production of a standard "MIR Report." At the ~~Administrator's~~~~Commissioner's~~ sole discretion, the evaluation fee may be increased up to an additional \$250.00 if the time required for the record review, evaluation, or production of the MIR Report is extraordinary. All non-routine test(s) for an impairment rating essential under the applicable edition of the AMA Guides to the Evaluation of Permanent Impairment shall have been performed prior to the evaluation. Routine tests necessary for a complete evaluation, such as range of motion or spirometry tests, should be performed by the MIR Registry physician as part of the evaluation at no additional cost. Any additional xrays that the registry physician deems necessary to render the MIR Report must be approved in writing by the Program Coordinator and are subject to the Medical Fee Schedule.

(3) Cancellations. To be considered timely, notice of a party's desire to cancel an evaluation appointment shall be given to the Program Coordinator at least three (3) business days prior to the date of the evaluation. An evaluation may be canceled or rescheduled only after obtaining the consent of the ~~Administrator~~~~Commissioner~~. The ~~Administrator~~ ~~Commissioner~~ shall decide whether an evaluation may be rescheduled within ten (10) calendar days of a request to cancel.

(a) If the request is not timely, the MIR Registry physician shall be entitled to collect/retain a \$300.00 cancellation fee. If the evaluation is rescheduled, the MIR Registry physician is entitled to the entire evaluation fee (for the scheduled evaluation) in addition to this fee.

1. If the claimant fails to appear for the evaluation with good cause, the Program Coordinator shall reschedule the evaluation.

2. If the claimant fails to appear for the evaluation without good cause as determined by the ~~Administrator~~~~Commissioner~~, this may be deemed a refusal to comply with a reasonable request for medical examination and the injured employee's right to compensation may be suspended pursuant to Tenn. Code Ann. § 50-6-204(d)(8) and no compensation shall be due and payable while the injured employee continues such refusal.

#### **0800-02-20-.09 COMMUNICATION WITH REGISTRY PHYSICIANS.**

(1) During the MIR physician selection process, registry physicians cannot render opinions as to the impairment relating to the subject injury to a party to the case in cases in which the physician's name appears on the three-physician listing. MIR Registry physicians who have rendered an opinion as to the impairment relating to the subject injury to a party to the case must disclose the nature and extent of those discussions to the ~~Administrator~~ ~~Commissioner~~ immediately upon their selection as the MIR registry physician. The ~~Administrator~~~~Commissioner~~, in his or her sole authority, will determine whether or not a conflict of interest exists. Failure to disclose a potential conflict of interest may result in a physician's removal from the MIR Registry. While removed from the Registry, physicians shall not be eligible to perform MIR evaluations.

#### **0800-02-20-.13 REMOVAL OF A PHYSICIAN FROM THE REGISTRY.**

(1) The ~~Administrator~~~~Commissioner~~, upon the advice of the Medical Director, may remove a physician from the MIR Registry permanently or temporarily. In doing so, the ~~Administrator~~ ~~Commissioner~~ shall first notify the physician in writing that he or she is at risk of being removed from the MIR Registry. The procedures followed for removal under this section shall follow the same procedures as those set forth below in Rule 0800-02-20-.13(2) and (3). The ~~Administrator~~ ~~Commissioner~~ may remove a physician from the MIR Registry permanently or temporarily based upon any of the following grounds:

(a) Misrepresentation on the "Application for Appointment to the MIR Registry" as determined by the ~~Administrator~~~~Commissioner~~;

(b) Failure to timely report a conflict of interest in a case assignment, as determined by the ~~Administrator~~~~Commissioner~~;

(c) Refusal or substantial failure to comply with the provisions of these Rules, including, but not limited to, failure to determine impairment ratings correctly using the AMA Guides, as determined by the Medical Director;

(d) Failure to maintain the requirements of the Rules, as determined by ~~the~~~~the Administrator~~ ~~Commissioner~~; or

- (e) Any other reason for the good of the Registry as determined solely and exclusively by ~~the~~ the Administrator Commissioner.
- (2) Written complaints regarding any MIR Registry physician shall be submitted to the Program Coordinator. Upon receipt of a complaint regarding a MIR Registry physician, the Administrator Commissioner shall send written notice of the complaint (or in cases arising under Rule 0800-02-20-.13(1), notice and grounds for possible removal) to such physician, stating the grounds, and notifying the physician that he or she is at risk of being removed from the MIR Registry.
- (a) The physician shall have thirty (30) calendar days from the date the Notice of Complaint in which to respond in writing to the complaint(s), and may submit any responsive supporting documentation to the Program Coordinator for consideration. Failure of the physician to submit a timely response to the Notice of Complaint may result in removal of the physician from the MIR Registry.
- (b) The ~~Administrator Commissioner~~, in consultation with the Medical Director, shall consider the complaint(s) and any response(s) from the physician in reaching a decision as to whether the physician shall be removed from the MIR Registry, and if removed, whether the removal will be permanent or temporary.
- (c) Upon reaching a determination on the complaint(s), the Administrator Commissioner shall issue a written Notice of Determination and set forth the basis for the decision in such Notice. The determination set forth shall become final fifteen (15) calendar days after issuance of the Notice of Determination, unless a timely request for reconsideration is received.
- (d) A MIR Registry physician may seek reconsideration of an adverse decision from the Administrator Commissioner by submitting a request for reconsideration stating the grounds for such reconsideration to the Program Coordinator within fifteen (15) calendar days of the issuance of the Notice of Determination. The Administrator Commissioner may affirm, modify or reverse the initial determination upon reconsideration of the initial decision. The Administrator Commissioner shall issue a Notice of Determination upon Reconsideration which shall be the final decision. If the Administrator Commissioner does not act on the request for reconsideration within twenty (20) calendar days, then the request shall be deemed to have been denied, which shall be the final decision.
- (3) A physician who has been removed from the MIR Registry by the Administrator Commissioner may apply for reinstatement six (6) months after the date of removal by submitting a written request to the Program Coordinator.

#### **0800-02-20-.14 PENALTIES.**

- (4) If any party engages in unauthorized communications with the MIR physician, then the Administrator Commissioner or Administrator's Commissioner's designee is authorized to assess a penalty of up to \$500.00 per violation against that party.
- (5) Notwithstanding any other provision in these rules to the contrary, and in addition to any other penalty provided for in these Rules and the Act, failure by any party to comply with these Rules in a manner for which no penalty has specifically been set forth herein may subject that party to civil penalties of \$100.00 per violation, as determined by the Administrator Commissioner.

#### **0800-02-20-.15 TIME LIMITS.**

- (1) All time limits referenced in these Rules may be extended by the Administrator Commissioner in his or her sole and exclusive discretion.