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TENNESSEE WORKERS' COMPENSATION

UTILIZATION REVIEW RULES – SUMMARY

(Eff. 11-12-2009)

A. *GENERAL PROVISIONS*

- UR rules “shall apply to all recommended treatments”.
- Employers “shall establish” and maintain a system of UR.
- Sanctions or civil penalties can result from failure to have a UR system.
- The Medical Director *or a WC Specialist* may determine whether the UR was conducted in conformity with the rules and have the authority to deem the UR void if it does not comply with the rules.
- UR providers must register with the Division of WC.
- Same individual cannot perform Nurse Case Management and UR on same claim.
- UR agent can contact the authorized treating physician (“ATP”) when evaluating medical necessity of prescribed treatment.
- ATP must provide records and reasons supporting necessity to UR agent. ATP can charge employer a fee for costs of copying and transmitting records.
- An RN can approve treatment. **A denial must be from an active, Tennessee-licensed, board-certified physician who is in good standing and who “is in the same or similar general specialty as the recommending ATP.”**
- UR is mandatory “whenever a dispute arises as to the medical necessity of a recommended treatment.”

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- If a UR denial is appealed, then the UR agent shall send a copy of the UR report and all supporting documentation to the Division of WC “upon request.”

B. CONTENTS OF UR REPORT

- An approval of the recommended treatment must be in writing, but need not be in a certain form.
- A denial must consider the “medical necessity, appropriateness, efficiency, and quality of the recommended treatment for the employee’s condition.”
- A denial “must contain specific and detailed reasons for the denial.”
- A denial must include the name, address, telephone number and qualifications of the physician making the denial.
- An appeal form must be provided with the denial (see form C-35A attached).

C. *TIME LIMITS*

- UR must be initiated within 3 business days of notification of prescribed treatment from ATP.
- Adjuster (as agent of employer) must inform all parties *and any WC Specialist assigned to the case* of the initiation of UR (See Form C-35).
- UR agent should complete UR determination within 7 business days.
- If the UR agent has insufficient information to make a UR determination, “it shall *immediately* make a written request for such information to the ATP.”
- The ATP must comply with a written request for more information within 5 business days of receipt of the request. (The 7 day deadline for a UR determination is tolled until either the agent receives the additional information from the ATP or the ATP’s 5-day deadline expires.)
- If the ATP fails to respond with 5 business days, the UR agent can deny the treatment for inadequate information. (An ATP who fails to cooperate with a request for information can be subject to sanctions and/or civil penalties.)
- Adjuster (or employer) must provide written notification of a denial to the employee and ATP within 3 business days of receipt of the denial from the UR agent. (The adjuster can overrule the UR denial and authorize the treatment, with conditions, if the adjuster so chooses.)
- Adjuster (or employer) must forward the UR determination (whether an approval or a denial) to any WC Specialist assigned to the claim within 3 business days of receipt from the UR agent.
- The Employee or ATP must initiate any appeal of a UR denial to the Division of WC within 30 calendar days of receipt of the denial.
- The Division will determine the necessity of the recommended treatment within 25 calendar days of receipt of all “necessary information.”
- Employer **MUST** pay for the appeal within 10 business days of the issuance of the Division’s determination (late fee of 10% per day).

- If the Division reverses a denial, then the WC Specialist shall issue an Order and the employer/insurer may be subject to penalties.
- During the pendency of an appeal, the employer/insurer can agree to override the UR denial and approve the treatment. Such a decision terminates the appeal and NO FEE shall be required.

EXCERPTS FROM THE TNDOL WEBSITE:**UTILIZATION REVIEW****The "UR" system provides for:**

Review of selected outpatient and inpatient health care providers; and
Pre-admission review of all hospital admissions, except for emergency services.

Utilization review is required in every case where the medical necessity of a recommended treatment is disputed.

Utilization review services must be provided or contracted for by:

Each insurer who provides workers' compensation insurance in Tennessee.

Every self-insured employer.

The insured employer may choose to provide the services on its own or through a third party administrator.

The UR Agent conducting the review services must be registered with the Division of Workers' Compensation.

Recommended treatments may only be denied by an Advisory Medical Practitioner (an actively TN-licensed practitioner, who is board-certified and in the same or similar general specialty as the authorized treating physician). Recommended treatments may be approved by an Advisory Medical Practitioner or registered nurse. UR Agents may employ or contract with individual Advisory Medical Practitioners and registered nurses.

The UR rules, Chapter 0800-02-06 (<http://www.tennessee.gov/sos/rules/0800/0800-02/0800-02.htm>) provide for specific timeframes in which to complete UR and to notify the parties of the UR determination.

A health care provider who is found to have rendered excessive or inappropriate services may be subjected to:

Forfeiture of the right to payment for the services rendered;
Payment of civil penalty of up to \$1,000;

Temporary or permanent suspension of the right to provide medical care services for workers' compensation claims.

An employer, insurer, third party administrator, or UR Agent who is found to have violated the UR rules may be subjected to a penalty of not less than \$100 nor more than \$1,000 per violation. 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.

What is utilization review and when is it required?

Utilization review is the evaluation, by an outside source, of the necessity, appropriateness, efficiency, and quality of medical care services provided to an injured employee.

Utilization review is required:

When the medical necessity of a recommended treatment is disputed or when otherwise required by the workers' compensation statutes or medical fee schedule (e.g., hospital admissions, physical or occupational therapy, chiropractic care, clinical psychological treatment).

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