DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation
7 CCR 1101-3
WORKERS' COMPENSATION RULES OF PROCEDURE

Rule 16 UTILIZATION STANDARDS

16-1 STATEMENT OF PURPOSE

(A) In an effort to comply with its legislative charge to assure appropriate and timely medical care at a reasonable cost, the Director of the Division of Workers' Compensation (Division) has promulgated these utilization standards, effective January 1, 2006. This rule defines the standard terminology, administrative procedures and dispute resolution procedures required to implement the Division's Medical Treatment Guidelines and Medical Fee Schedule." All providers and payers shall use the "Medical Treatment Guidelines," Rule 17, and the "Medical Fee Schedule," Rule 18, as incorporated and defined in the Workers' Compensation Rules of Procedure, 7 CCR 1101-3.

16-2 STANDARD TERMINOLOGY FOR THIS RULE

The following terms are used throughout Rules 16 and 18 and are defined as indicated:

(A) **Ambulatory Surgical Center (ASC)** – licensed as an ambulatory surgery center by the Colorado Department of Public Health and Environment.

(B) **Authorized Treating Provider** (ATP) – (may be any of the following):

(1) the initial treating physician chosen by either the employer or insurer, or, in the absence of choice, the health care provider chosen by the injured worker;

(2) a health care provider to whom an authorized treating physician refers the injured worker for treatment, consultation, or impairment rating;

(3) a provider who is designated by agreement of the injured worker and the payer; or

(4) a provider selected by the injured worker with permission from the payer, the Division, or after a hearing with an administrative law judge.

(C) **Billed Service(s) --** any billed service, procedure, equipment or supply provided to an injured worker by a provider.

(D) **Billing Party --** a service provider or an injured worker who has incurred authorized medical costs.

(E) **Certificate of Mailing --** a signed and dated statement containing the names and mailing addresses of all persons receiving copies of attached or referenced document(s), certifying the documents were placed in the U.S. Mail, postage pre-paid, to those persons.

(F) **Children's Hospital** – as identified and Medicare certified by the Colorado Department of Public Health and Environment.

(G) **Convalescent Center** – as licensed by the Colorado Department of Public Health and Environment.

(H) **Critical Access Hospital (CAH)** – as identified and Medicare certified by the Colorado Department of Public Health and Environment.

(I) **Day --** for the purpose of Rule 16, day is defined as a calendar day unless otherwise noted.

(J) **Hospital --** the Division incorporates the definition established by the Colorado Department of Public Health and Environment in its Rules of Procedure, 6 CCR 1011-1, Chapter 1, Definitions.

(K) **Long-Term Care Facility** – as identified and Medicare certified by the Colorado Department of Public Health and Environment.

(L) **MCAC --** Medical Care Advisory Committee to the Director.

(M) **Medical Fee Schedule --** Division's Rule 18 and the documents incorporated by reference in that rule.

(N) **Medical Treatment Guidelines --** the medical treatment guidelines as incorporated into Rule 17, "Medical Treatment Guidelines."

(O) **Payer --** an **insurer**, employer, or their designated agent(s) who is responsible for payment of medical expenses.

(P) **Primary rural Health Facility** –as identified and Medicare certified by the Colorado Department of Public Health and Environment.

(Q) **Private Psychiatric Facilities** – Licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

(R) **Provider --** a **person** or entity providing authorized healthcare service to a worker in connection with work-related injury or occupational disease.

(S) **Rehabilitation Facilities** – licensed as a rehabilitation hospital by the Colorado Department of Public Health and Environment.

(T) **State Psychiatric Hospitals and State Mental Health Institutions** – licensed as a psychiatric facility and operated by the state.

(U) **"Supply et al."** -- any single supply, durable medical equipment (DME), orthotic, prosthesis or single drug dose that costs the provider an amount greater than $300.00, and all implants regardless of their cost.

(V) **Veterans' Administration Medical Facilities** – all medical facilities overseen by the Federal Veterans' Administration.

16-3 REQUIRED USE OF THE MEDICAL TREATMENT GUIDELINES

When an injury or occupational disease falls within the purview of Rule 17 "Medical Treatment Guidelines" and the date of injury occurs on or after July 1, 1991, providers shall use the medical treatment guidelines, in effect, to prepare their treatment plan(s) for the injured worker.

16-4 REQUIRED USE OF THE MEDICAL FEE SCHEDULE

When services provided to an injured worker fall within the purview of the medical fee schedule, all payers shall use the fee schedule to determine maximum allowable fees.

16-5 RECOGNIZED HEALTH CARE PROVIDERS

(A) Physician and Non-Physician Providers

(1) For the purpose of this rule, recognized health care providers are divided into the major categories of "physician" and "non-physician". Recognized providers are defined as follows:

(a) "Physician providers" are those individuals who are licensed by the State of Colorado through one of the following state boards:

(1) Colorado State Board of Medical Examiners;

(2) Colorado State Board of Chiropractic Examiners;

(3) Colorado Podiatry Board; and

(4) Colorado State Board of Dental Examiners.

(b) "Non-physician providers" are those individuals who are registered or licensed by the State of Colorado Department of Regulatory Agencies, or certified by a national entity recognized by the State of Colorado as follows:

(1) Audiologist (CCC-AUD) – certified by the American Speech/Language and Hearing Association or board certified in audiology from the American Board of Audiology;

(2) Acupuncturist (LAc) – licensed by the Office of Acupuncturist Registration, Colorado Department of Regulatory Agencies;

(3) Licensed Clinical Social Worker (LCSW) – licensed by the Colorado State Board of Social Work Examiners;

(4) Licensed Practical Nurse (LPN) – licensed by the Colorado State Board of Nursing;

(5) Licensed Professional Counselor (LPC) – licensed by the Colorado State Board of Professional Counselor Examiners;

(6) Marriage and Family Therapist (LMFT) – licensed by the Colorado State Board of Marriage and Family Therapist Examiners;

(7) Advanced Practice Nurse– licensed by the Colorado State Board of Nursing; Advanced Practice Nurse Registry;

(8) Occupational Therapist (OTR) – certified by the National Occupational Therapy Certification Board;

(9) Optometrist (OD) – licensed by the Colorado State Board of Optometric Examiners;

(10) Orthopedic Technologist (OTC) – certified by the Board for Certification of Orthopedic Technologists, National Association of Orthopedic Technologists;

(11) Psychologist (PsyD, PhD, EdD) – licensed by the Colorado State Board of Psychologist Examiners;

(12) Physical Therapist (LPT) – licensed by the Colorado State Board of Physical Therapy;

(13) Physician Assistant (PA) – licensed by the Colorado State Board of Medical Examiners;

(14) Registered Nurse (RN) – licensed by the Colorado State Board of Nursing;

(15) Respiratory Therapist (RTL) – certified by the National Board of Respiratory Care and licensed by the Colorado Department Of Regulatory Agencies;

(16) Speech Language Pathologist (CCC-SLP) – certified by the American Speech and Hearing Association; and

(17) Surgical Technologist (CST) – certified under direction of the Association of Surgical Technologists.

(2) Any provider not listed in Rule 16-5(A)(1)(a) or (b) must comply with Rule 16-9, Prior Authorization when providing all services.

(3) All non-physician providers must have a referral from an authorized treating physician. An authorized physician making the referral to any listed or unlisted non-physician provider is required to clarify any questions concerning the scope of the referral, prescription, or the reasonableness or necessity of the care.

(4) Any listed or non-listed non-physician provider is required to clarify any questions concerning the scope of the referral, prescription, or the reasonableness or necessity of the care with the referring authorized treating physician.

(5) Any healthcare provider must be an "authorized treating provider (ATP)" in each specific workers' compensation case to obtain payment. An authorized provider is defined in Rule 16-2(B).

(B) Upon request, healthcare providers must provide copies of license, registration, certification or evidence of healthcare training for billed services.

(C) Out-of-State Provider

(1) Injured Worker Relocated

(a) Upon receipt of the "Employer's First Report of Injury" or the "Worker's Claim for Compensation" form, the payer shall notify the injured worker

that the procedures for change-of-provider, should s/he relocate out-of-state, can be obtained from the payer.

(b) A change of provider must be made:

(1) Through referral by the injured worker's authorized provider; or

(2) In accordance with § 8-43-404 (5)(a), C.R.S.

(2) Injured Worker Referred

In the event an injured worker has not relocated out-of-state but is referred to an out-of-state provider for treatment or services not available within Colorado, the referring provider shall obtain prior authorization from the payer as set forth in Rule 16-9. Prior Authorization, and 16-10. Contest of a Request for Prior Authorization. The referring provider's written request for out-of-state treatment shall include the following information:

(a) Medical justification prepared by the referring provider;

(b) Written explanation as to why the requested treatment/services cannot be obtained within Colorado;

(c) Name, complete mailing address and telephone number of the out-of-state provider;

(d) Description of the treatment/services requested, including the estimated length of time and frequency of the treatment/service, and all associated medical expenses; and

(e) Out-of-state provider’s qualifications to provide the requested treatment or services.

(3) The Colorado fee schedule should govern reimbursement for out-of-state providers.

16-6 BILLING RATES AND FEES

(A) Payment for billed services identified in the fee schedule shall not exceed those scheduled rates and fees, or the provider's actual billed charges, whichever is less.

(B) Payment for billed services not identified or identified but without established value in the fee schedule shall require prior authorization from the payer as set forth in Rule 16-9 Prior Authorization and Rule 16-10 Contest of a Request for Prior Authorization. Determination of the payment amount shall be made by the payer and reflect the complexity, time, level of training and expertise required to perform the service or procedure, but shall at no time exceed the amount billed. The methodology for determination of payment used by the payer shall be made available to the provider upon request. If the payer uses a usual and customary rate data base (UCR), the payer must specify the percentile used, the zip code used and the source of the data base. Rule 16-11, Payment of Medical Benefits, sets forth the procedures for contesting any portion of a bill. If there are no reasonable methods to determine a fee, the payer shall pay the billed charges.

(C) Payment for a “Supply et al.” shall be the provider’s cost plus 20%.

16-7 REQUIRED BILLING FORMS AND ACCOMPANYING DOCUMENTATION

(A) Providers may use electronic reproductions of any required form(s) referenced in this section; however, any such reproduction shall be an exact duplication of such form(s) in content and appearance.

(B) Required Billing Forms

All health care providers shall use only the following billing forms or electronically produced formats when billing for services:

(1) CMS (Centers for Medicare & Medicaid Services) 1500 - shall be used by all providers billing for professional services, durable medical equipment (DME) and ambulance with the exception of those providers billing for dental services or procedures; hospitals are required to use the CMS 1500 when billing for professional services.

(2) UB-92 - shall be used by all hospitals, Children's Hospitals, CAHs, Veterans' Administration Facilities, home health and facilities meeting the definitions found in Rule 16-2 when billing for hospital services or any facility fees billed by any other provider, such as ASCs, except for urgent care which may use the CMS 1500.

(3) American Dental Association's Dental Claim Form, Version 2002 shall be used by all providers billing for dental services or procedures.

(4) With the agreement of the payer, the ANSI ASC X12 (American National Standards Institute Accredited Standards Committee) or NCPDP (National Council For Prescription Drug Programs) electronic billing transaction containing the same information as in (a), (b) or (c) in this subsection may be used.

(C) Required Billing Codes

All billed services shall be itemized on the appropriate billing form as set forth in Rule 16-7(A) and (B), and shall include applicable billing codes and modifiers from the fee schedule.

(D) Inaccurate Billing Forms or Codes

Payment for any services not billed on the forms identified and/or not itemized as instructed in Rule 16-7(B) and (C), may be contested until the provider complies. However, when payment is contested, the payer shall comply with the applicable provisions set forth in Rule 16-11 Payment of Medical Benefits

(E) Accompanying Documentation

(1) Authorized treating physicians submit to the payer, with their initial and final visit billings, a completed "Physician's Report of Workers' Compensation Injury" (Form WC164) specifying:

(a) The report type as "initial" when the injured worker has their initial visit with the authorized treating physician for this workers' compensation injury. This form shall includes completion of items 1-7 and 10. Note that certain information in Item 2 (such as Insurer Claim #) may be omitted if not known by the provider.

(b) The report type as “closing” when the physician determines the injured worker has reached maximum medical improvement (MMI) for all injuries or diseases covered under this workers’ compensation claim. The form requires the completion of items 1-5, 6.B, C, 7, 8 and 10. If the injured worker has sustained a permanent impairment, then item 9 must be completed also and the following additional information shall be attached to the bill at the time MMI is determined:

(1) All necessary permanent impairment rating reports when the authorized treating physician is Level II Accredited, or

(2) The name of the Level II Accredited physician designated to perform the permanent impairment rating when a rating is necessary and the authorized treating physician is not determining the permanent impairment rating.

(2) At no charge, the physician shall supply the injured worker with one legible copy of all completed “Physician’s Report of Workers’ Compensation Injury (WC164) forms at the time the form is completed.

(3) The provider shall submit to the payer the completed WC164 form as specified in Rule 16-7(E), no later than fourteen (14) days from the date of service.

(4) Providers, other than hospitals, shall provide the payer with all supporting documentation at the time of submission of the bill unless other agreements have been made between the payer and provider. This shall include copies of the examination, surgical, and/or treatment records.

(5) Hospital documentation shall be available to the payer upon request. Payers shall specify what portion of a hospital record is being requested. (For example, only the emergency room (ER) chart notes, in-patient physician orders and chart notes, x-rays, pathology reports, etc.)

(6) In accordance with Rule 16-11, the payer may contest payment for billed services until the provider completes and submits the required accompanying documentation as specified by Rule 16-7(E).

16-8 REQUIRED MEDICAL RECORD DOCUMENTATION

(A) A provider shall maintain medical records for each injured worker when the provider intends to bill for the provided services.

(B) All medical records shall contain legible documentation substantiating the services billed. The documentation shall itemize each contact with the injured worker and shall detail at least the following information per contact or, at a minimum for cases where contact occurs more than once a week, be summarized once per week:

(1) Patient's name;

(2) Date of contact, office visit or treatment;

(3) Name and professional designation of person providing the billed service;

(4) Assessment or diagnosis of current condition with appropriate objective findings;

(5) Treatment status or patient's functional response to current treatment;

(6) Treatment plan including specific therapy with time limits and measurable goals and detail of referrals;

(7) If being completed by an authorized treating physician, all pertinent changes to work and/or activity restrictions which reflect lifting, standing, stooping, kneeling, hot or cold environment, repetitive motion or other appropriate physical considerations; and

(8) All prior authorization(s) for payment received from the payer (i.e., who approved the prior authorization for payment, services authorized, dollar amount, length of time, etc.).

16-9 PRIOR AUTHORIZATION

(A) Prior authorization for payment shall be requested by the provider when:

(1) A prescribed service exceeds the recommended limitations set forth in the medical treatment guidelines;

(2) The medical treatment guidelines otherwise require prior authorization for that specific service;

(3) A prescribed service is identified within the medical fee schedule as requiring prior authorization for payment; or

(4) A prescribed service is not identified in the fee schedule as referenced in Rule 16-6(B).

(B) All prior authorization for a prescribed service or procedure may be granted immediately and without medical review. However, the payer shall respond to all providers requesting prior authorization within seven (7) business days from receipt of the provider's completed request as defined in Rule 16-9(E). To complete the contest, refer to procedures in Rule 16-10.

(C) The payer, upon receipt of the "Employer's First Report of Injury" or a "Worker's Claim for Compensation," shall give written notice to the injured worker stating that the requirements for obtaining prior authorization for payment are available from the payer.

(D) The payer, unless they have previously notified said provider, shall give notice to the provider of these procedures for obtaining prior authorization for payment upon receipt of the Division form titled "Physician's Report of Workers' Compensation Injury" (WC164).

(E) To complete a prior authorization request, the provider shall concurrently explain the medical necessity of the services requested and provide relevant supporting medical documentation. Supporting medical documentation is defined as documents used in the provider's decision-making process to substantiate the need for the requested service or procedure.

(F) To contest a request for prior authorization, the payer is required to comply with the provisions outlined in Rule 16-10.

(G) The Division recommends payers confirm in writing, to providers and all parties, when a request for prior authorization is approved.

(H) If, after the service was provided, the payer agrees the service provided was reasonable and necessary, lack of prior authorization for payment does not warrant denial of payment.

16-10 CONTEST OF A REQUEST FOR PRIOR AUTHORIZATION

(A) If the payer contests a request for prior authorization for non-medical reasons as defined under Rule 16-11(B)(1), the payer shall notify the provider and parties, in writing, of the basis for the contest within seven (7) business days. A certificate of mailing of the written contest must be sent to the provider and parties.

(B) If the payer is contesting a request for prior authorization for medical reasons, the payer shall, within seven (7) business days of the completed request:

(1) Have the request reviewed by a physician or other health care professional, as defined in Rule 16-5(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review; and

(2) The reviewing provider may call the requesting provider to expedite communication and processing of prior authorization requests. However, the written contest or approval still needs to be completed within the specified seven (7) days under Rule 16-10(B).

(3) Furnish the provider and the parties with either a verbal or written approval, or a written contest that sets forth the following information:

(a) An explanation of the specific medical reasons for the contest, including the name and professional credentials of the person performing the medical review and a copy of the medical reviewer's opinion;

(b) The specific cite from the Division’s Medical Treatment Guidelines exhibits to Rule 17, when applicable;

(c) Identification of the information deemed most likely to influence the reconsideration of the contest when applicable; and

(d) A certificate of mailing to the provider and parties.

(C) Prior Authorization Disputes

(1) The requesting party or provider shall have seven (7) business days from the date of the certificate of mailing on the written contest to provide a written response to the payer, including a certificate of mailing. The response is not considered a "special report" when prepared by the provider of the requested service.

(2) The payer shall have seven (7) business days from the date of the certificate of mailing of the response to issue a final decision, including a certificate of mailing to the provider and parties.

(3) In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures under Rule 8.

(D) An urgent need for prior authorization of health care services, as recommended in writing by an authorized treating provider, shall be deemed good cause for an expedited hearing.

(E) Failure of the payer to timely comply in full with the requirements of Rule 16-10(A) or Rule 16-10(B), shall be deemed authorization for payment of the requested treatment unless a hearing is requested within the time prescribed for responding as set forth in Rule 16-10(A) or (B).

(F) Unreasonable delay or denial of prior authorization, as determined by the director or an administrative law judge, may subject the payer to penalties under the Workers' Compensation Act.

16-11 PAYMENT OF MEDICAL BENEFITS

(A) Uncontested Payment For Billed Services

(1) Providers shall submit their bills for services rendered within one hundred twenty (120) days of the date of service. Bills first received later than one hundred twenty (120) days may be denied unless extenuating circumstances exist.

(2) Unless contested in accordance with the provisions set forth in this section 16-11(B) and (C), all bills submitted by a provider are due and payable in accordance with the Medical Fee Schedule within thirty (30) days after receipt of the bill by the payer. Date of receipt may be established by the payer's date stamp or electronic acknowledgement date; otherwise, receipt is presumed to occur three (3) days after the date the bill was mailed to the payer's correct address. The payer shall notify the billing provider that the injured worker shall not be balance-billed for services related to a compensable work-related injury or occupational disease.

(3) In the event the injured worker has directly paid a medical provider for uncontested medical services, the payer shall reimburse the injured worker for actual costs incurred for authorized services within thirty (30) days after receipt of the bill by the payer. If the actual costs exceed the maximum fee allowed by the medical fee schedule (Rule 18), the payer may seek a refund from the medical provider for the difference between the amount charged to the injured worker and the maximum fee. Each request for a refund shall indicate the service provided and the date of service(s) involved.

(4) When the payer fails to make timely payment of uncontested billed services, the billing party shall first attempt to resolve payment with the payer. Where such attempt is unsuccessful, the billing party may request assistance from the Division's Carrier Practices Unit.

(B) Contested Payment for Billed Services Based on Non-Medical Issues.

(1) Non-medical reasons for contesting payment may include, but are not limited to: compensability has not been established; the billed services are not related to the admitted injury; the provider is not authorized to treat; the insurance coverage is at issue; or the billed code does not appear to be accurate based upon the information submitted.

(2) In all cases where a billed service is contested for non-medical reasons by the payer, the payer shall, within thirty (30) days of receipt of the bill, submit to the billing party a written notification of contest.

The written non-medical notification of contest shall include the following information:

(a) Name of the injured worker;

(b) Date(s) of service(s) being contested;

(c) Payer's accident number and/or Division's workers' compensation claim number;

(d) If applicable, acknowledgement of specific uncontested and paid items submitted on the same bill as contested services;

(e) Reference to the bill and each item of the bill being contested;

(f) Reason(s) for contesting the payment of any item. The explanation shall include the citing of appropriate statutes, rules and/or documents supporting the payer's reasons for contesting payment; and

(g) Notice that the billing party may resubmit the bill or corrected bill within sixty (60) days.

(3) Prior to modifying a billed code, the payer must contact the billing provider and determine if the modified code is accurate.

(a) If the billing provider agrees with the payer, then the payer shall process the service with the agreed upon code and shall document on their explanation of benefits (EOB) the agreement with the provider. The EOB shall include the name of the person at the provider's office who made the agreement.

(b) If the provider is in disagreement, then the payer shall proceed according to Rule 16-11(B)(2) or 16-11(C), as appropriate.

(4) If the payer agrees a service or procedure was reasonable and necessary, the provider's lack of prior authorization for payment does not warrant denial of liability for payment.

(C) Contested Payment for Billed Services Based on Medical Issues:

The payer shall within thirty (30) days of receipt of the medical bill and supporting medical documentation do the following:

(1) Have the request reviewed by a physician or other healthcare professional as defined in Rule 16-5(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. This reviewing provider may call the billing provider to expedite communication and timely processing of the contested or paid medical bill. However, the written contest or payment still needs to be completed within the specified thirty (30) days under Rule 16-11.

(2) Furnish the provider and the parties with a written contest setting forth the following information:

(a) An explanation of the specific medical reasons for the decision, including the name and professional credentials of the person performing the medical review and a copy of the medical reviewer's opinion;

(b) The specific cite from the Division's Medical Treatment Guidelines exhibits to Rule 17, when applicable;

(c) Identification of the information deemed most likely to influence the reconsideration of the contest, when applicable; and

(d) A certificate of mailing to the provider and parties.

(D) Medical Bill Disputes

(1) The billing party shall have sixty (60) days to respond to the payer's written notification of contest. The payer shall have thirty (30) days to respond to the provider's response to the notification of contest. If the parties are unable to resolve a dispute relating to the Medical Fee Schedule, either party may contact the Medical Policy Unit (MPU) at the Division.

(2) When seeking clarification or dispute resolution from the MPU, the requesting party must provide:

(a) A copy of the bill with the contested codes and dates of services in dispute;

(b) A copy of the payer's explanation as to why the billed services are being contested; and

(c) A copy of any applicable medical record documentation.

The MPU will try to provide a written analysis and opinion to the parties regarding the appropriate application of the Medical Fee Schedule within thirty (30) days of receipt of the complete documentation and the written request for assistance; or as soon thereafter as possible.

(3) In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.

(E) Retroactive Adjustments of Medical Bills

(1) All medical bills paid by a payer shall be considered final unless adjustments are made within twelve months after the date of the original explanation of benefits.

(2) A written notice shall be sent to a provider prior to any recovery of overpayments being undertaken by the payer. The written notice shall contain complete and specific explanation of the amounts being recovered, the specific reasons why these amounts are believed to be overpayments, and evidence that these payments were in fact made. The provider shall have at least 60 days to respond to the written notice before any recovery of the overpayment is started.

(F) Contracts between providers and payers shall comply with Rule 16-11.

16-12 ONSITE REVIEW OF HOSPITAL OR OTHER MEDICAL CHARGES

(A) The payer may conduct a review of billed and non-billed hospital or medical facility charges related to a specific workers' compensation claim.

(B) The payer shall comply with the following procedures:

Within thirty (30) days of receipt of the billing, notify the hospital or other medical facility of its intent to conduct a review. Notification shall be in writing and shall set forth the following information:

(1) Name of the injured worker;

(2) Claim and/or hospital or other medical facility I.D. number associated with the injured worker's bill;

(3) An outline of the items to be reviewed; and

(4) If applicable, the name, address and telephone number of any person who has been designated by the payer to conduct the review (reviewer).

(C) The hospital or other medical facility shall comply with the following procedures:

(1) Allow the review to begin within thirty (30) days of the payer's notification;

(2) Upon receipt of the patient's signed release of information form, allow the reviewer access to all items identified on the injured worker's signed release of information form;

(3) Designate an individual(s) to serve as the primary liaison(s) between the hospital or other medical facility and the reviewer who will acquaint the reviewer with the documentation and charging practices of the hospital or other medical facility;

(4) Provide a written response to each of the preliminary review findings within ten (10) days of receipt of those findings; and

(5) Participate in the exit conference in an effort to resolve discrepancies.

(D) The reviewer shall comply with the following procedures:

(1) Obtain from the injured worker a signed information release form;

(2) Negotiate the starting date for the review;

(3) Assign staff members who are familiar with medical terminology, general hospital or other medical facility charging and medical records documentation procedures or have a level of knowledge equivalent at least to that of an LPN;

(4) Establish the schedule for the review which shall include, at a minimum, the dates for the delivery of preliminary findings to the hospital or other medical facility, a 10-day response period for the hospital or other medical facility, and the delivery of an itemized listing of discrepancies at an exit conference upon the completion of the review; and

(5) Provide the payer and hospital or other medical facility with a written summary of the review within twenty (20) working days of the exit conference.