RULE XV

MEDICAL UTILIZATION REVIEW

A. STATEMENT OF PURPOSE

1. This rule is promulgated to implement and establish procedures for the medical utilization review program, by which the treatment rendered by a health care provider to a workers' compensation claimant may be professionally reviewed on issues of whether such treatment is reasonable, necessary and/or appropriate according to accepted professional standards.

B. REQUESTS FOR UTILIZATION REVIEW

1. A party shall request a utilization review on a case-by-case basis by filing the Request for Utilization Review form (request form) prescribed by the Division. In order to reduce costs, the request form may be photocopied/duplicated or reproduced using computer type devices as long as either process results in an exact reproduction of the form in both appearance and content.

2. The provider under review shall remain as an authorized provider for the associated claimant until the director or an administrative law judge issues an order to the contrary as a result of the utilization review process. The provider shall continue to submit bills for services rendered to the associated claimant during the review period and the insurance carrier shall continue to pay the provider's bills as provided in these rules of procedure.

3. As provided in section C., below, an information package and medical records package shall be filed with the request form.

C. FILING A REQUEST FOR UTILIZATION REVIEW

1. One copy of an information package shall be filed and shall contain the following items:

   a. A completed and signed Division prescribed request form,

   b. Copies of all admissions filed or orders entered in the case,

c. A list containing the full names and medical degrees of all providers, including the provider under review, other treating providers, and individuals who are considered as referrals or who performed consultations, independent medical examinations and/or second opinions, and

d. The minimum filing fee as provided in section C.6.

2. Seven (7) identical copies of a medical records package shall be filed with the request form and each copy shall contain the following items:

a. A case report which shall be prepared, signed and dated by a licensed medical professional. This report shall be dated within thirty (30) days prior to the date of filing with the Division. The case report shall be limited to the following:

(1) Name, discipline of care and specialty of the provider under review,
(2) Claimant's standard demographic information (age, sex, marital status, etc.),
(3) Claimant's employer and occupation/job title,
(4) Date(s) of claimant's work-related injury/exposure(s), and
(5) Date of initial treatment, a brief chronological history of treatment to the present date, and any significant contributing factors which may have had a direct effect on the length of treatment (e.g., diabetes).

b. Table of contents

c. The following sections:

Section 1 - a copy of the Employer's First Report of Injury and/or the Worker's Claim for Compensation form.
Section 2 - all reports, notes, etc., from the provider under review as submitted to the requesting party.
Section 3 - all reports, notes, etc., of other treating providers as submitted to the requesting party.

Section 4 - all reports resulting from referrals, consultations, independent medical examinations and second opinions as submitted to the requesting party.
Section 5 - all diagnostic test results as submitted to the requesting party.
Section 6 - all medical management reports as submitted to the requesting party.
Section 7 - all hospital/clinic records related to the injury as submitted to the requesting party.

3. The medical records package shall not contain billing statements, adjustor notes, vocational rehabilitation records, surveillance tapes or reports, admissions, denials or comments directed to the utilization review committee.

4. In order to reduce costs, all material contained in the medical records package shall be presented in identified sections, each section's contents presented in chronological order.

5. In order to reduce costs, the presentation of the medical records package shall be as follows:

   a. Seven (7) separate and identical copies.

   b. Each copy two-hole punched at the top center of each page and securely fastened. Notebooks and plastic type covers and binders shall not be used.

   c. A blank sheet of paper shall be placed and bound to the front and back of each copy of the submitted material.

   d. If tabs are used to divide sections, they shall be positioned to the right side of the document.

6. A minimum filing fee of $1,250.00 shall be paid at the time of filing by the requesting party. The Division shall notify the requesting party of additional costs incurred which require a supplemental fee.

D. OFFICIAL NOTIFICATION OF UTILIZATION REVIEW

1. The Division shall notify in writing the provider under review of the review request. Each party to the case shall receive a copy of the written notification as their official notification of the review request.

2. The provider under review shall receive, as an attachment to the written notification, one copy of the medical records package as filed by the requesting party. Each party to the case shall receive one copy of the medical records package as filed by the requesting party.

E. ADDING MEDICAL RECORDS TO THE UTILIZATION REVIEW FILE

1. The Division shall not accept additional medical records filed by any individual who has not been identified as a party to the case.

2. The Division shall incorporate all properly and timely filed additional medical records into the review file as provided in sections E.3. through E.5., below.

3. Parties filing additional medical records should not duplicate records already submitted for review.

4. Each party has thirty (30) days from the mailing of the review notification to file additional medical records. Absent a timely showing of good cause, any additional medical records shall not be filed after the specified time.

5. The presentation of additional medical records shall be as follows:

    a. The first item in each copy shall be a dated and signed transmittal letter which contains the following information:

        (1) The UR# and claimant's name,
        (2) Submitting party name and position in the case,
        (3) A certification stating the seven (7) copies of additional medical records contain the same documents, and
        (4) An index of the attached material.

b. The presentation of the additional medical records is identical to those provided in section C.5., above.

6. Each party to the case shall receive from the Division a copy of all properly filed additional medical records.

F. Selection Of Utilization Review Committee Members

1. The director, with input from the medical director, shall appoint appropriate peer professionals to serve on the utilization review committees for three years.

2. A committee member may be suspended from participation if the member has been the subject of a utilization review which resulted in an order for change of provider, retroactive denial of payment and/or revocation of accreditation.

3. Committee members shall be paid a fee of $225 per hour for their time incurred in preparing and completing their reports and recommendations to the director. Services rendered by the committee members on behalf of the Division shall be concluded upon acceptance by the Division of their final reports and recommendations. Any party to a claim for benefits or any party to a utilization review proceeding who requests the presence as a witness of one or more committee members at a proceeding for any purpose, by subpoena or otherwise, shall be responsible for payment to said committee member(s) pursuant to the fee schedule set forth in these rules of procedure.

4. A provider may not serve on a UR Committee unless his or her professional license or certification, if applicable, is current, active and unrestricted.

5. Members of UR Committees shall not engage in communication regarding the Utilization Review with any person other than Division staff, except under the following circumstances: by approval of the director; by written agreement of the parties to the case, including the provider under review; by order of an administrative law judge; or by deposition or subpoena as approved by an administrative law judge.

G. Composition of Utilization Review Committees

1. The composition of the utilization review committees shall reflect a fair balance of interests. Committees shall be established to review cases submitted for utilization review. Membership of the committees will include the following:

a. Joints/Musculoskeletal Committee – Two practitioners licensed in the same discipline of care as the provider under review and one occupational medicine practitioner (M.D. or D.O.) with a minimum of 2 years experience in occupational medicine where 30% of practice time is in occupational

medicine cases or a minimum of 5 years of experience with a minimum of 15% of practice time in occupational medicine cases;

b. Dental Committee (Teeth only) - Three dentists;

c. Psychiatry Committee - One occupational medicine practitioner (M.D. or D.O.) and two psychiatrists; and

d. Other - Committee shall be determined by the director to meet the specific circumstances of the utilization review case.

H. RESPONSIBILITIES OF UTILIZATION REVIEW COMMITTEE MEMBERS

1. Each committee member shall work independently while performing his/her review. The review shall be a paper review only unless a specialist opinion is requested by a majority of the committee members. The specialist's opinion may require a physical examination of the claimant.
2. When performing a utilization review, the members of the medical utilization review committee shall consider all applicable medical treatment guidelines under these rules of procedure. The Division shall provide copies of the appropriate guidelines to the committee upon request.

3. Report of the Utilization Review Committee

   a. The report of each member of the utilization review committee shall be restricted to specific questions submitted by the Division.

   b. Each committee member shall prepare and submit a written narrative demonstrating how the answers were determined for each of the questions as provided in section H.3.a., above.

I. CHANGE OF MEDICAL PROVIDER

1. If the director orders that a change of provider be made, the claimant and insurer or self-insured employer shall notify the Division, on the prescribed form, as to whether the parties have agreed upon a new provider. The parties may request mediation or pre-hearing services from the Division to assist them in this matter.

2. If the claimant chooses to remain under the care of the provider under review during the period of appeal resolution, the payor shall be responsible for payment of medical bills to the provider until an order on appeal is issued. If the insurance carrier, employer or self-insured employer prevails on appeal, the claimant may be held liable by the prevailing party for such medical costs paid during the appeal period.

3. A provider who wishes to participate in the UR Program as a new treating provider candidate shall not be eligible unless his or her professional license or certification, if applicable, is current, active and unrestricted.

J. UTILIZATION REVIEW APPEALS

1. The appealing party shall complete the appeal form prescribed by the Division. The form shall be filed with the Medical Utilization Review coordinator.

2. Should the appealing party be entitled to a de novo hearing, the hearing shall be scheduled according to the instructions on the appeal form.