DEPARTMENT OF LABOR AND EMPLOYMENT

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

Rule 10 Medical Utilization Review

10-1 REQUESTS FOR UTILIZATION REVIEW

(A) A party shall request a utilization review by filing the Request for Utilization Form (request form) with the Division Utilization Review Coordinator. The request form must be the one prescribed by the Division, but a duplicated or reproduced request form may be used as long as it is an exact version of the original in both appearance and content.

(B) The provider under review shall remain as an authorized provider for the associated claimant during the medical 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.

(C) As provided in section 10-2, below, an information package and medical records package shall be filed with the request form.

10-2 FILING A REQUEST FOR UTILIZATION REVIEW

(A) One copy of an information package shall be filed and shall contain the following items:

(1) completed and signed Division prescribed request form.

(2) copies of all admissions filed or orders entered in the case.

(3) 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

(4) The minimum filing fee as provided in section 10-2(E)

(B) In addition, seven (7) copies of a medical records package shall be filed in accordance with the instructions on the prescribed request form, Each copy shall be two-hole punched at the top center of each page and securely fastened. (Notebooks and plastic type covers and binders shall not be used). A blank sheet of paper shall be placed and bound to the front and back of each copy of the submitted material and if tabs are used to divide sections, they shall be positioned to the right side of the document and each copy shall contain the following items:

(1) A table of contents;

(2) 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 pursuant to § 8-43-501(2)(b). The case report shall be limited to the following:

(a) name, discipline of care and specialty of the provider under review,

(b) claimant's standard demographic information (age, sex, marital status, etc.),

(c) claimant's employer and occupation/job title, date(s) of claimant's work-related injury/exposure(s), and,

(d) 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).

(e) A brief statement from the medical professional after review of the medical records in support of utilization review.

(3) 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 the 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.

(C) 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.

(D) All material contained in the medical records package shall be presented in identified sections, each section's contents presented in chronological order.

(E) A minimum filing fee of $ 1,250.00 shall be paid at the time of filing by the requesting party. The Division will notify the requesting party of additional costs incurred, such as payment to panelists not covered by the filing fee, which require a supplemental fee. Payment of any such supplemental fee will be required for completion of the utilization review and prior to the issuance of the Director's order.

10-3 OFFICIAL NOTIFICATION OF UTILIZATION REVIEW

(A) The Division will notify in writing the provider under review of the review request, and provide a copy of the written notification to each party to the case.

(B) Along with the written notification, the provider under review, as well as each party to the case, will receive one copy of the medical records package as filed by the requesting party.

(C) Within seven (7) days of receiving the written notification, the provider under review may submit a concise written statement no longer than two (2) pages in length, limited to whether the treatment provided was reasonably necessary or reasonably appropriate. The provider shall supply seven (7) copies of the statement to the Division. A timely and properly submitted written response will be added to the review packets and forwarded to all parties by the Division.

(D) Any motions or requests regarding the utilization review must be submitted, in writing, to the Medical Utilization Review Coordinator. Until such time as the Director issues a final order, the medical utilization review is an internal process at the Division, under the jurisdiction of the Director.

10-4 ADDING MEDICAL RECORDS TO THE UTILIZATION REVIEW FILE

(A) The Division will not accept additional medical records filed by any individual who has not been identified as a party to the case.

(B) The Division will incorporate all properly and timely filed additional medical records into the review file. Additional medical records that are not filed timely and properly will not be included in the review file.

(C) Parties filing additional medical records should not duplicate records already submitted for review. Seven copies of any additional medical records must be provided.

(D) The provider under review and each party to the case shall have one opportunity to submit additional medical records. Medical records must be received or postmarked within thirty (30) days from the mailing of the review notification. This thirty (30) day period can be extended upon a written request which sets forth good cause.

(E) Any additional medical records shall be presented as follows:

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

(a) The UR # and claimant's name,

(b) Identification of the submitting party name and relationship to the case,

(c) a certification stating the seven (7) copies of additional medical records contain the same documents, and

(d) an index of the additional attached medical records material.

(2) The presentation of any additional medical records shall be in an identical manner to those as provided in section 10-2(B), above.

(F) The Division will send the provider under review and each party to the case a copy of all properly filed additional medical records.

10-5 SELECTION OF UTILIZATION REVIEW COMMITTEE MEMBERS

(A) The Director, with input from the Medical Director, shall appoint appropriate peer professionals to serve on the utilization review committees for three years.

(B) 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 of medical bills and/or revocation of accreditation.

(C)) 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.

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

(E) After the members of the utilization review committee have been established, the provider and each party to the case will receive written notice of the names of the committee members. Within ten (10) days of receiving the written notification, any allegation that a committee member has a conflict and should be removed from the committee must be submitted in writing to the medical utilization review coordinator, setting forth the basis for the alleged conflict. Any such allegations that are not raised in a timely manner are deemed to have been waived and will not be considered at any subsequent stage of the utilization review proceedings. A conflict will be presumed to exist when the provider under review and a member of the review committee have a relationship which involves a direct or substantial financial interest. The following guidelines apply to any allegations of conflict under this Rule:

(1) Direct or substantial financial interest is a substantial interest which is a business ownership interest, a creditor interest in an insolvent business, employment or prospective employment for which negotiations have begun, ownership interest in real or personal property, debtor interest or being an officer or director in a business.

(2) The relationship will be reviewed as of the time the utilization review is being conducted. Relationships in existence before or after the review in and of themselves will have no bearing, unless a direct or substantial financial interest is raised at the time of the utilization review.

(3) Being members of the same professional association or medical group, sharing office space or having practiced together in the past are not the types of relationships which will be considered a conflict, absent a direct or substantial financial interest.

(4) Any provider who has provided services to the claimant in the case for which the utilization review has been requested, or who has any type of personal or

professional relationship with the claimant, will not be allowed to serve on the utilization review committee.

(5) This rule is not intended as an opportunity to conduct discovery. Depositions, interrogatories or any other type of discovery will not be permitted in order to make determinations as to whether a conflict exists.

(F) Members of UR Committees shall not review any material other than what is provided by the Division, and 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; the provider under review and the parties to the case are strictly prohibited from having any communication with the members of the UR committee while the review is pending.

10-6 COMPOSITION OF UTILIZATION REVIEW COMMITTEES

(A) The Division will strive to compose utilization committees that reflect a balance of interests. Membership of the committees may include the following:

(1) 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;

(2) Dental Committee (Teeth only)--three dentists;

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

(4) Other--Committee shall be determined by the Director to meet the specific circumstances of the utilization review case.

10-7 RESPONSIBILITIES OF UTILIZATION REVIEW COMMITTEE MEMBERS

(A) Each committee member shall perform the review based on the materials provided, and 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.

(B) 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.

(C) The report of each member of the utilization review committee should be limited to answers to the specific questions submitted by the Division, along with a written narrative supporting or explaining the answers for each of the questions.

10-8 CHANGE OF MEDICAL PROVIDER

(A) If the Director orders that a change of provider be made, the claimant and insurer or self-insured employer shall follow the procedures set forth in § 8- 43-501(4) in order to obtain

a new provider. The parties shall notify the Division, on the prescribed form, as to whether the parties have agreed upon a new provider or whether the Director shall select the new provider as provided in § 8-43-501(4).

(B) 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.

(C) A provider who wishes to become a new treating provider candidate shall not be eligible unless his or her professional license or certification, if applicable, is current, active and unrestricted.

10-9 UTILIZATION REVIEW APPEALS

(A) The appealing party shall complete the appeal form prescribed by the Division. The form shall be filed with the Medical Utilization Review coordinator within the timeframes set forth in the appeal procedures.

(B) Should the Director order both retroactive denial of fees and change of provider, upon appeal the issues shall be separated and transferred to the Office of Administrative Courts for a de novo hearing on retroactive denial or a record review for change of provider.

(C) Should the appealing party be entitled to a de novo hearing, the hearing shall be scheduled according to the instructions on the appeal form. The appealing party must file an application for hearing with the Office of Administrative Courts and a copy must be provided to the Medical Utilization Review Coordinator.