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

In an effort to comply with its legislative charge to assure appropriate and timely medical care at a reasonable cost, the Director (Director) of the Division of Workers' Compensation (Division) has promulgated these utilization standards, effective January 1, 2011. 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. With respect to any matter arising under the Colorado Workers' Compensation Act and/or the Workers' Compensation Rules of Procedure and to the extent not otherwise precluded by the laws of this state, all providers and payers shall use and comply with the provisions of 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 RULES 16 AND 18

(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 treating physician designated by the employer and selected 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 health care provider selected by the injured worker when the injured worker has the right to select a provider;

(4) A health care provider authorized by the employer when the employer has the right or obligation to make such an authorization;

(5) A health care provider determined by the director or an administrative law judge to be an ATP;

(6) A provider who is designated by the agreement of the injured worker and the payer.

(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 – as identified and licensed by the Colorado Department of Public Health and Environment.

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

(L) Medical Fee Schedule – Division's Rule 18, its Exhibits, and the documents incorporated by reference in that rule.

(M) Medical Treatment Guidelines – the medical treatment guidelines as incorporated into Rule 17, "Medical Treatment Guidelines."

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

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

(P) Provider – a person or entity providing authorized health care service, whether involving treatment or not, to a worker in connection with work-related injury or occupational disease.

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

(R) Rural Health Facility – as identified and Medicare certified by the Colorado Department of Public Health and Environment.

(S) Skilled Nursing Facility (SNF) – licensed as a skilled nursing facility 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, biologic, or single drug dose, for which the billed amount exceeds $500.00 and all implants.

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

16-3 REQUIRED USE OF THE MEDICAL TREATMENT GUIDELINES AND PAYMENT FOR SERVICE

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 and payers shall use the medical treatment guidelines, in effect at the time of service, to prepare or review their treatment plan(s) for the injured worker. A payer may not dictate the type or duration of medical treatment. Nor may a payer rely solely on its own internal guidelines or other standards for medical determination. When treatment exceeds or is outside of the Medical Treatment Guidelines, prior authorization is required. In all instances of contest appropriate processes to deny are required. Refer to applicable sections of Rule 16-9, 16-10 and/or 16-11.

16-4 REQUIRED USE OF THE MEDICAL FEE SCHEDULE

(A) 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.

(B) All providers are required to report services in accordance with codes and standards in Rule 18 Medical Fee Schedule that accurately represent the services provided. The medical fee schedule sets the maximum allowable payment but the fee schedule does not limit the billing charges.

(C) The provider may be subject to penalties under the Workers’ Compensation Act for inaccurate billing when the provider knew or should have known that the services billed were inaccurate, as determined by the Director or an administrative law judge..

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

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

(3) Athletic Trainers (ATC) – certified by the Board of Certification, Inc. (BOC);

(4) Audiologist (AU.D., CCC-A) – certified by the American Speech Language-Hearing Association or board certified in audiology from the American Board of Audiology;

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

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

(7) Massage Therapist (RMT) – registered as a massage therapist by the Colorado Department of Regulatory Agencies;

(8) Occupational Therapist (OTR) – registered by the Colorado Department of Regulatory Agencies as an occupational therapist certified by the National Board for Certification of Occupational Therapy;

(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) Pharmacist – licensed by the Colorado State Board of Pharmacy;

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

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

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

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

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

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

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

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

(3) 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.

(4) Referrals:

(a) A payer or employer shall not redirect or alter the scope of an authorized treating provider's referral to another provider for treatment or evaluation of a compensable injury. Any party who has concerns regarding a referral or its scope shall advise the other parties and providers involved.

(b) 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.

(c) 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) Rule 18 Medical Fee Schedule applies to authorized services provided in relation to a specific workers' compensation case.

(B) 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 HANDLING, PROCESSING AND PAYMENT OF MEDICAL BILLS

(A) Use of agents, including but not limited to PPO networks, bill review companies, third party administrators (TPAs) and case management companies, shall not relieve the employer or insurer from their legal responsibilities for compliance with these rules.

(B) 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.

(C) 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.

(D) Any payer contesting a provider's treatment shall follow the procedures as outlined under Rule 16-10 Contest of a Request For Prior Authorization or Rule 16-11 Payment of Medical Benefits.

(E) The payer should note that ICD-9 Supplementary Classification of External Causes of Injury and Poisoning codes (E-codes), when submitted, shall not be used to establish the work relatedness of an injury or treatment.

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. With the agreement of the payer, identifying information may be placed in the margin of the form.

(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 (08-05) - 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 (08-05) when billing for professional services. Health care providers shall provide their name and credentials in an appropriate box of the CMS 1500 (08-05).

(2) UB-04 - shall be used by all hospitals, hospital-based ambulance/air services, 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 (08-05).

(3) American Dental Association's Dental Claim Form, Version 2006 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 (1), (2) or (3) 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. National provider identification (NPI) numbers are required for workers' compensation bills; providers who are not permitted to obtain NPI numbers are exempt from this requirement. When billing on a CMS 1500 (08-05), the NPI should be that of the rendering professional at the line level whenever possible.

(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 sign (or countersign) and 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 managing the total workers' compensation claim of the patient. Generally, this will be the designated or selected authorized treating physician. When applicable, the emergency room or urgent care authorized treating physician for this workers' compensation injury may also create a WC 164 initial report. Unless requested or prior authorized by the payer in a specific workers' compensation claim, no other authorized physician should complete and bill for the initial WC 164 form. This form shall include 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 authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient determines the injured worker has reached maximum medical improvement (MMI) for all injuries or diseases covered under this workers' compensation claim, with or without a permanent impairment. 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 (generally the designated or selected physician) managing the total workers' compensation claim of the patient is Level II Accredited; or

(2) Referral to a Level II Accredited physician requested to perform the permanent impairment rating when a rating is necessary and the authorized treating physician (generally the designated or selected physician)

managing the total workers' compensation claim of the patient is not determining the permanent impairment rating.

(c) 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.

(d) 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.

(2) 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.

(3) 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.)

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

(F) Providers shall submit their bills for services rendered within one hundred twenty (120) days of the date of service or the bill may be denied unless extenuating circumstances exist. Extenuating circumstances may include but are not limited to delays in compensability being decided or the provider has not been informed where to send the bill.

16-8 REQUIRED MEDICAL RECORD DOCUMENTATION

(A) A treating 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(C).

(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). The duty to respond to a provider's written request applies without regard for who transmitted the request.

(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 initial bill from that provider.

(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 from receipt of the provider's completed request as defined in Rule 16-9(E). A certificate of mailing of the written contest must be sent to the provider and parties.

If an ATP requests prior authorization and indicates in writing, including their reasoning and relevant documentation, that they believe the requested treatment is related to the admitted workers' compensation claim, the insurer cannot deny based solely on relatedness without a medical review as under Rule 16-10(B).

(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 all the submitted documentation under Rule 16-9(E) 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) After reviewing all the submitted documentation, 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 available through the Division or Office of Administrative Courts.

(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 (B), shall be deemed authorization for payment of the requested treatment unless:

(1) a hearing is requested within the time prescribed for responding as set forth in Rule 16-10(A) or (B), and

(2) the requesting provider is notified that the request is being contested and the matter is going to hearing.

(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) Payer Requirements for Processing Medical Service Bills

(1) For every medical service bill submitted by a provider, the payer shall reply with a written notice or explanation of benefits. In those instances where the payer reimburses the exact billed amount, identification of the patient's name, the payer, the paid bill, the amount paid and the dates of service are required. If any adjustments are made then the payer's written notice shall include:

(a) Name of the injured worker or patient;

(b) Specific identifying information coordinating the notice with any payment instrument associated with the bill;

(c) Date(s) of service(s), if date(s) was(were) submitted on the bill;

(d) Payer's claim number and/or Division's workers' compensation claim number, if one has been created;

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

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

(g) For compensable services for a work-related injury or occupational disease the payer shall notify the billing provider

that the injured worker shall not be balance-billed for services related to the work-related injury or occupational disease;

(h) Name of insurer with admitted, ordered or contested liability for the workers' compensation claim, when known;

(i) Name, address, e-mail (if any), phone number and fax of a person who has responsibility and authority to discuss and resolve disputes on the bill;

(j) Name and address of the employer, when known;

(k) If applicable, a statement that the payment is being held in abeyance because a relevant issue is being brought to hearing.

(2) The payer shall send the billing party written notice that complies with 16-11(A)(1) within thirty (30) days of receipt of the bill. Any notice that fails to include the required information set forth in 16-11(A)(1) is defective and does not satisfy the payer's 30-day notice requirements set forth in this section.

(3) Unless the payer provides timely and proper reasons as set forth by the provisions outlined in 16-11(B) - (D), 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.

(4) If the payer discounts a bill and the provider requests clarification in writing, the payer shall furnish to the requester the specifics of the discount within 30 days including a copy of any contract relied on for the discount. If no response is forthcoming within 30 days, the payer must pay the maximum fee schedule allowance or the billed charges, whichever is less.

(5) Date of receipt of the bill may be established by the payer's date stamp or electronic acknowledgement date; otherwise, receipt is presumed to occur three (3) business days after the date the bill was mailed to the payer's correct address.

(6) Unreasonable delay in processing payment or denial of payment of medical service bills, as determined by the Director or an administrative law judge, may subject the payer to penalties under the Workers' Compensation Act.

(7) If the payer fails to make timely payment of uncontested billed services, the billing party may report the incident to the Division's Carrier Practices Unit who may use it during an audit.

(B) Process for Contesting Payment of Billed Services Based on Non-Medical Reasons

(1) Non-medical reasons are administrative issues. Examples of non-medical reasons for contesting payment include the following: no claim has been filed with the payer; 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; typographic,

gender or date errors are in the bill; failure to submit any medical documentation at all; unrecognized CPT® code.

(2) If an ATP bills for medical services and indicates in writing, including their reasoning and relevant documentation, that they believe the medical services are related to the admitted WC claim, the payer cannot deny based solely on relatedness without a medical review as under Rule 16-11(C).

(3) In all cases where a billed service is contested for non-medical reasons, the payer shall send the billing party written notice of the contest within 30 days of receipt of the bill. The written notice shall include all of the notice requirements set forth in 16-11(A)(1) and shall also include:

(a) Date(s) of service(s) being contested, if date(s) was(were) submitted on the bill;

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

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

(d) Clear and persuasive reasons for contesting the payment of any item specific to that bill including the citing of appropriate statutes, rules and/or documents supporting the payer's reasons for contesting payment.

Any notice that fails to include the required information set forth in this section is defective and does not satisfy the notice requirement set forth in this section. Such defective notice shall not satisfy the payer's 30 day notice requirement set forth in this section.

(4) 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) or 16-11(C), as appropriate.

(5) 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) Process for Contesting Payment of Billed Services Based on Medical Reasons

When contesting payment of billed services based on medical reasons, the payer shall:

(1) Have the bill and all supporting medical documentation under Rule 16-7(E) 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. After reviewing the supporting medical documentation, the reviewing provider may call the billing provider to expedite communication and timely processing of the contested or paid medical bill.

(2) In all cases where a billed service is contested for medical reasons, the payer shall send the provider and the parties written notice of the contest within thirty (30) days of receipt of the bill. The written notice shall include all of the notice requirements set forth in 16-11(A)(1) and shall also include:

(a) Date(s) of service(s) being contested, if date(s) was(were) submitted on the bill;

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

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

(d) An explanation of the clear and persuasive 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;

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

(f) Identification of the information deemed most likely to influence the reconsideration of the contest, when applicable.

Any notice that fails to include the required information set forth in this section is defective and does not satisfy the notice requirement set forth in this section. Such defective notice shall not satisfy the payer's 30-day notice requirement set forth in this section.

(D) Process for Ongoing Contest of Billed Services

(1) The billing party shall have sixty (60) days to respond to the payer's written notice under 16-11(A) – (C). The billing party's timely response must include:

(a) A copy of the original or corrected bill;

(b) A copy of the written notice or EOB received;

(c) A statement of the specific item(s) contested;

(d) Clear and persuasive supporting documentation or clear and persuasive reasons for the appeal; and

(e) Any available additional information requested in the payer's written notice.

(2) If the billing party responds timely and in compliance with Rule 16-11(D)(1), the payer shall:

(a) When contesting for medical reasons, have the bill and all supporting medical documentation and reasoning under 16-7(E) and, if applicable, 16-11(D)(1) 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. After reviewing the provider's documentation and response, the reviewing provider may call the billing provider to expedite communication and timely processing of the contested or paid medical bill.

(b) When contesting for non-medical reasons, have the bill and all supporting medical documentation and reasoning under 16-7(E) and, if applicable, 16-11(D)(1) reviewed by a person who has knowledge of the bill. After reviewing the provider's documentation and response, the reviewing person may call the billing provider to expedite communication and timely processing of the contested or paid medical bill.

(3) If before or after conducting a review pursuant to 16-11(D)(2), the payer agrees with the billing party's response, the billed service is due and payable in accordance with the Medical Fee Schedule within thirty (30) days after receipt of the billing party's response. Date of receipt may be established by the payer's date stamp or electronic acknowledgement date; otherwise, receipt is presumed to occur three (3) business days after the date the response was mailed to the payer's correct address.

(4) After conducting a review pursuant to 16-11(D)(2), if there is still a dispute regarding the billed services, the payer shall send the billing party written notice of contest within thirty (30) days of receipt of the response. The written notice shall include all of the notice requirements set forth in 16-11(A)(1) and shall also include:

(a) Date(s) of service(s) being contested, if date(s) was(were) submitted by the provider;

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

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

(d) An explanation of the clear and persuasive medical or non-medical reasons for the decision, including the name and professional credentials of the person performing the medical or non-medical review and a copy of the medical reviewer's opinion when the contest is over a medical reason; and

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

Any notice that fails to include the required information set forth in this section is defective and does not satisfy the notice requirement set forth in this section. Such defective notice shall not satisfy the payer's 30-day notice requirement set forth in this section.

(5) 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) When seeking clarification or dispute resolution from the Division's Medical Policy Unit (MPU), the requesting party must provide:

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

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

(3) 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.

(F) Retroactive review of Medical Bills

(1) All medical bills paid by a payer shall be considered final at twelve months after the date of the original explanation of benefits unless the provider is notified that:

(a) a hearing is requested within the twelve month period, or

(b) a request for utilization review has been filed pursuant to § 8-43-501.

(2) If the payer conducts a retroactive review to recover overpayments from a provider based on medical reasons, the payer shall have the bill and all supporting documentation 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. The payer shall send the billing party written notice that shall include all of the notice requirements set forth in 16-11(A)(1) and shall also include:

(a) Reference to each item of the bill where payer seeks to recover overpayments; and

(b) Clear and persuasive medical reason(s) for seeking recovery of overpayment(s). The explanation shall include the citing of

appropriate statutes, rules, and/or other documents supporting the payer's reason for seeking to recover overpayment; and

(c) Evidence that these payments were in fact made to the provider.

(3) If the payer conducts a retroactive review to recover overpayments from a provider based on non-medical reasons, the payer shall send the billing party written notice that shall include all of the notice requirements set forth in 16-11(A)(1) and shall also include:

(a) Reference to each item of the bill where payer seeks to recover overpayments; and

(b) Clear and persuasive reason(s) for seeking recovery of overpayment(s). The explanation shall include the citing of appropriate statutes, rules, and/or other documents supporting the payer's reason for seeking to recover overpayment; and

(c) Evidence that these payments were in fact made to the provider.

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

(G) An injured worker shall never be required to directly pay for admitted or ordered medical benefits covered under the Workers' Compensation Act. In the event the injured worker has directly paid for medical services that are then admitted or ordered as covered under the Workers' Compensation Act , the payer shall reimburse the injured worker for the amounts actually paid for authorized services within thirty (30) days after receipt of the bill. If the actual costs exceed the maximum fee allowed by the medical fee schedule, 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.

(H) To the extent not otherwise precluded by the laws of this state, contracts between providers, payers and any agents acting on behalf of providers or 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) business 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 business 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) business days of the exit conference.