

September 18, 2019

DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation

7 CCR 1101-3

WORKERS' COMPENSATION RULES OF PROCEDURE

Rule 10 Medical Utilization Review

This rule implements the medical utilization review program set forth in §§ 8-43-501 and 8-43-503. The rule applies to all parties, providers, and peer professionals involved in the program.

In computing any period of time prescribed or allowed by this rule, the parties shall refer to Rule 1-2. All references to "days" shall mean calendar days unless otherwise stated. All references to "years" shall mean twelve calendar months.

10-1 REQUESTS FOR UTILIZATION REVIEW

A party shall request a utilization review with the Division's Utilization Review Coordinator.

(A) Fees:

The requesting party shall pay a non-refundable fee of \$1,000.00 at the time of filing. The Division will notify the requesting party of additional costs incurred, such as payment to peer professionals not covered by the filing fee. Payment of any such supplemental fee will be required to complete the utilization review and prior to the issuance of the Director's order.

(B) Request Packet:

The requesting party shall electronically file one (1) copy of a request packet for the Division's use only that contains the following items:

- (1) completed and signed Request for Utilization Review form.
- (2) copies of all admissions filed or orders entered in the case. The Director may limit the scope of the utilization review based upon prior orders addressing the reasonableness and necessity of care by the provider under review.
- (3) a list containing the names, practice/company names, specialties, and medical degrees of all providers, including the provider under review, other treating providers, consulting providers, independent medical examiners, and providers who have issued second opinions.

(C) Medical Records Packet:

The requesting party also shall file one (1) electronic and one (1) paper copy of a medical records packet in accordance with the instructions on the Request for Utilization Review form. The two copies shall be identical in content and organization. The medical records packet shall contain the following items:

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(1) A Case Review Report form completed, signed, and dated by a licensed medical professional, pursuant to § 8-43-501(2)(b). This form shall be completed within thirty (30) days prior to the date of filing the request for utilization review with the Division.

(2) The medical records shall be organized as follows:

Section 1--all reports, notes, etc., from the provider under review as submitted to the requesting party.

Section 2--other reports, notes, etc., the requesting party believes are relevant to the utilization review.

Each section shall be organized to enable efficient review by the Division, peer professionals, the provider under review, and the claimant (e.g., chronologically, by provider, or by type of treatment).

(3) The medical records packet shall not contain billing statements, adjuster notes, vocational rehabilitation records, surveillance tapes or reports, admissions, denials, orders, hearing transcripts, or comments directed to the utilization review committee, unless otherwise ordered by the Director.

(D) Payment of Medical Bills During Utilization Review:

The provider under review shall remain an authorized treating provider for the associated claimant during the medical utilization review process. The provider shall continue to bill for services rendered to the claimant during the review period. The payer shall continue to pay these bills pursuant to all applicable portions of Rules 16 and 18, until and unless the Director orders a change of provider, a denial of fees, or a revocation of the physician's accreditation status.

10-2 OFFICIAL NOTIFICATION OF UTILIZATION REVIEW

(A) The Division will notify in writing the provider under review the utilization review request has been filed 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 packet as filed by the requesting party.

(C) Within thirty (30) days of receiving the written notification, the provider under review may submit a statement, using the Division-prescribed form, limited to whether the treatment provided was reasonably necessary or reasonably appropriate. The provider shall supply one (1) electronic copy of the statement to the Division. The 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 Division's Utilization Review Coordinator. Any motion to strike part(s) of a response to the utilization review request or a medical records packet shall be made by scheduling a prehearing conference within 10 days of receiving the response/packet, with notice to all interested parties.

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10-3 ADDING MEDICAL RECORDS TO THE UTILIZATION REVIEW FILE

- (A) 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 that sets forth good cause.
- (B) Parties filing additional medical records shall not duplicate records already submitted for review. Parties shall provide one (1) electronic and one (1) paper copy of any additional medical records for inclusion into the review file. The electronic and paper copies of additional medical records shall be identical in content and organization.
- (C) Additional medical records shall be presented as follows:
 - (1) The first item shall be a cover letter containing the UR #, the claimant's name, submitting party's name/relationship to the case, and an index listing the provider and the date of each additional medical record.
 - (2) The presentation of any additional medical records shall be organized to enable efficient review by the Division, peer professionals, the provider under review, and the claimant (e.g., chronologically, by provider, or by type of treatment).
- (D) The Division will send the provider under review and each party to the case a copy of all properly filed additional medical records.

10-4 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.
- (B) Committee members shall be paid 80% of the special report fee under Rule 18 per hour for preparing and timely completing their reports and recommendations to the Director. Any party who requests the presence of a committee member as a witness shall be responsible for payment pursuant to the fee schedule set forth in Rule 18.
- (C) A provider may not serve on a utilization review committee unless his or her professional license or certification, if applicable, is current, active, and unrestricted.
- (D) After the utilization review committee has been established, the provider and each party to the case will receive written notice of the names of the committee members. Within seven (7) 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 Division's Utilization Review Coordinator, setting forth the basis for the alleged conflict. Any such allegations not raised in a timely manner are deemed to have been waived. A conflict is presumed to exist when the provider under review and a committee member have a relationship that involves a direct or substantial financial interest. The relationship will be reviewed at the time of the utilization review request.
 - (1) Direct or substantial financial interest is defined as a business ownership interest, a creditor interest in an insolvent business, employment or prospective

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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 relationships that will not be considered a conflict include being members of the same professional association, sharing office space, or having practiced together in the past.
 - (3) Any provider who has provided medical services as listed in section 10-1(B)(3) 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.
 - (4) The parties may not conduct discovery regarding the existence of any conflicts.
- (E) Committee members shall not communicate regarding the utilization review with any person other than Division staff, except by approval of the Director or written agreement of the parties to the case (including the provider under review). The provider under review and the parties to the case shall not communicate with the committee members while the review is pending.

10-5 COMPOSITION OF UTILIZATION REVIEW COMMITTEES

Membership of the committees may include the following:

- (A) Medical Committee:
- (1) Two practitioners in the same discipline of care as the provider under review and
 - (2) One practitioner (M.D. or D.O.) with a minimum of 2 years experience where a minimum 30% of practice time has been in occupational medicine or a minimum of 5 years experience where a minimum 15% of practice time has been in occupational medicine. This experience must be within the past 5 calendar years of the appointment to the committee. Alternatively, a physician without such recent experience must have served on a task force or an advisory panel that assisted the Division with the development of the Medical Treatment Guidelines within the past 5 calendar years.
- (B) Dental Committee--three practitioners;

10-6 RESPONSIBILITIES OF UTILIZATION REVIEW COMMITTEE MEMBERS

- (A) Each committee member shall work independently while performing his/her review.
- (B) When performing utilization review, each committee member shall consider all applicable Exhibits to Rule 17, the Medical Treatment Guidelines. If none of the Medical Treatment Guidelines apply, the committee members may consider other professional guidelines or standards of care.
- (C) The report of each committee member should be limited to answers to specific questions submitted by the Division and a written narrative supporting or explaining these answers. Each committee member shall submit his or her report by the deadline established by the

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Division's Utilization Review Coordinator. The Director may reduce the reimbursement due to the committee member for failure to timely submit his or her report.

10-7 CHANGE OF MEDICAL PROVIDER

- (A) If the Director orders a change of provider, the claimant and the payer shall follow § 8-43-501(4) to obtain a new provider. The selection of a new provider will proceed even if any appeal is filed. The parties shall notify the Division, on the prescribed form, whether they have agreed on a new provider or whether the Director shall select the new provider pursuant to § 8-43-501(4).
- (B) A new treating provider shall have a current, active and unrestricted professional license or certification.
- (C) The claimant shall schedule an appointment with the new provider within thirty (30) days of the notice of new provider selection, with the appointment to be held no later than forty five (45) days of the notice of new provider selection. If the claimant fails to schedule or attend the appointment, the payer may schedule the appointment. The payer shall not be responsible for paying the bills by the provider under review for costs incurred after the claimant attends the first appointment with the new provider or after the date of the scheduled appointment by the payer if the claimant failed to schedule or attend the appointment with the new provider.
- (D) Any party may appeal a Director's order granting or denying a change of provider with the Colorado Office of Administrative Courts within:
 - (1) forty days from the date of the certificate of mailing of the order if the claim involves a date of injury on or after July 1, 1991; or
 - (2) thirty days after the date of the certificate of mailing of an order if the claim involves a date of injury prior to July 1, 1991.

The appealing party shall provide a copy of all filings with the Office of Administrative Courts to the Utilization Review Coordinator. The review shall be limited to the record on appeal.

10-8 DENIAL OF FEES

- (A) The three year period for a retroactive denial of fees listed in § 8-43-501(3)(e) applies to claims involving a date of injury on or after July 1, 1991. Claims involving a date of injury prior to July 1, 1991 may be subject to a longer period of retroactive denial of fees.
- (B) Any party may appeal a Director's order granting or denying fees under §§ 8-43-501(3)(e) and -5(b) with the Colorado Office of Administrative Courts as follows:
 - (1) The provider appealing an order denying fees may request a *de novo* hearing before an administrative law judge by filing an application for hearing within thirty days from the date of the certificate of mailing of the order. The parties may file an appeal limited to the record within forty days from the date of the certificate of mailing of order if the claim involves a date of injury on or after July 1, 1991.

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- (2) thirty days of the receipt of the order if the claim involves a date of injury prior to July 1, 1991.

The appealing party shall provide a copy of all filings with the Office of Administrative Courts to the Utilization Review Coordinator.

10-9 REVOCATION OF ACCREDITATION

- (A) The Director, with input from the Medical Director, will review and give great weight to a committee recommendation that a provider's Level I or Level II accreditation status be revoked. The Director may issue an order to show cause why the accreditation should not be revoked and, following the provider's response, refer the matter for a hearing on the merits before an administrative law judge. The provider shall file an application for hearing within ten days of receiving the referral. All proceedings shall comply with § 8-42-101(3.6)(g) and Rule 13.
- (B) The provider appealing a Director's order revoking accreditation shall do so within twenty days after the date of the certificate of mailing of the order, in accordance with § 8-43-301.