

TITLE 20, COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. THE INDUSTRIAL COMMISSION OF ARIZONA

ARTICLE 13. TREATMENT GUIDELINES

Article 13, consisting of Sections R20-5-1301 through R20-5- 1312, made by final rulemaking at 22 A.A.R. 1730, effective October 1, 2016 (Supp. 16-2).

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ARTICLE 13. TREATMENT GUIDELINES

R20-5-1301. Adoption and Applicability of the Article

A. The Industrial Commission of Arizona (Commission) has adopted the Work Loss Data Institute's Official Disability Guidelines – Treatment in Workers Compensation (ODG) as the standard reference for evidence-based medicine used in treating injured workers within the context of Arizona's workers' compensation system. By adopting and referencing the most recent edition (at the time of treatment), and continuously updated Official Disability Guidelines, the Commission can ensure the latest available medical evidence is used in making medical treatment decisions for injured workers.

B. Until further action of the Commission, the guidelines shall apply to all body parts and conditions.

C. The Commission may modify or change the applicability of the guidelines as described in subsection (B) if the Commission determines that modification or changing the applicability of

the guidelines will: 1) improve medical treatment for injured workers, 2) make treatment and claims processing more efficient and cost effective, and 3) if the Commission's modification expands the applicability of the guidelines, the guidelines adequately cover the relevant body parts or conditions. Before taking action to modify or change the applicability of the guidelines, the Commission shall provide an opportunity for public comment and hold a public hearing. A decision of the Commission under this subsection shall be made by a majority vote of a quorum of Commission members present at a public meeting.

D. Action taken by the Commission to modify or change the applicability of the guidelines under subsection (C) shall be published in the minutes of the Commission meeting when such action was taken. The minutes of this action shall be published on the Commission's website and shall be available from the Commission upon request.

E. The guidelines shall apply prospectively. Recommendations provided in the guidelines related to the management of chronic pain and the use of opioids for all stages of pain management shall apply to medical treatment or services occurring on or after October 1, 2016. For purposes of this process, chronic pain shall be defined by the guidelines. Recommendations provided in the guidelines related to all other body parts and conditions shall apply to medical treatment or services occurring on or after October 1, 2018.

F. This Article applies to all claims filed with the Commission.

G. This Article only applies to medical treatment and services for body parts and conditions that have been accepted as compensable.

H. The guidelines are to be used as a tool to support clinical decision making and quality health care delivery to injured employees. The guidelines set forth care that is generally considered reasonable and are presumed correct if the guidelines provide recommendations related to the requested treatment or service. This is a rebuttable presumption and reasonable medical care may include deviations from the guidelines. To support a request to deviate from the guidelines, the provider must produce documentation and justification that demonstrates by a preponderance of credible medical evidence a medical basis for departing from the guidelines. Credible medical evidence may include clinical expertise and judgment.

I. The Commission shall provide administrative review and oversight of this Article.

R20-5-1302. Definitions

In this Article and R20-5-106(A)(12), unless the context otherwise requires:

“Act” means the Arizona Workers’ Compensation Act, A.R.S. Title 23, Chapter 6.

“Active Practice” means performing patient care for a minimum of eight hours per week in one of the five preceding years.

“Administrative Law Judge” or “ALJ” means a hearing officer appointed under A.R.S. § 23-108.02.

“Administrative Review” means a process that includes a peer review for preauthorization of a request for medical treatment or services conducted pursuant to R20-5-1311. The administrative review process will be managed by the Medical Resource Office (MRO) at the Industrial Commission of Arizona.

“American Board of Medical Specialties” means the organization that develops a uniform system for specialty boards to administer examinations for certification of physicians within specific medicine specialties.

“American Osteopathic Association” means the organization that develops a uniform system for specialty boards to administer examinations for certification of osteopathic physicians within specific osteopathic medicine specialties.

“Applicability” means the body parts and medical conditions that are covered under this Article and authorized by the Commission under R20-5-1301(B) and (C).

“Claim” means the workers’ compensation claim filed by the injured employee under the Act.

“Contractor” means an independent peer review organization accredited by URAC.

“Fast Track ALJ Dispute Resolution Program” or “fast track process” means the voluntary dispute resolution process set forth in R20-5-1312(B).

“International Classification of Diseases Code” or “ICD Code” means a set of medical diagnostic codes that creates a universal language for reporting diseases and injury.

“International Classification of Diseases” or “ICD” means an official list of categories of diseases, physical and mental, that is issued and maintained by the World Health Organization.

“IME” means an independent medical examination scheduled under R20-5-114.

“Injured Employee” means a person defined in A.R.S. § 23-901 whose claim has been accepted for workers’ compensation benefits.

“Medical File Review Opinions” means a formal examination of patient data and medical records for the purpose of determining the need for medical treatment, services or both.

“Payer” means an insurance carrier defined under A.R.S. § 23-901, a self-insured employer defined in R20-5-102, a third-party administrator, and the Special Fund of the Industrial Commission of Arizona.

“Peer Review” means an independent medical review conducted by an individual meeting the requirements of R20-5-1311(I). “Preauthorization” means the written request prescribed by R20-5-1303 from a provider to a payer requesting approval to provide medical treatment or services to an injured employee.

“Provider” means a physician as defined in R20-5-102.

“Reconsideration” means a written request to the payer or identified review organization by an injured employee or medical provider to reconsider a previous payer decision to deny medical treatment or services and that identifies the specific justification to support the request.

“Third-Party Administrator” means an organization that processes insurance or employee benefit claims for a separate entity.

“Treatment Guidelines” or “guidelines” means medical treatment guidelines that are used as a tool to support clinical decision making and quality health care delivery to injured employees.

“URAC” refers to URAC, a non-profit organization formerly known as the Utilization Review Accreditation Commission.

R20-5-1303. Provider Request for Preauthorization

A. No preauthorization is required under the Act to ensure payment for reasonably required medical treatment or services. While preauthorization is not required under the Act, a provider may seek preauthorization as provided in this subsection.

B. A provider shall submit a request for preauthorization in writing using Section I (Provider Request for Preauthorization) of the Medical Treatment Preauthorization Form approved by the Commission under R20-5-106(A)(12). A provider shall attach documentation to a request for preauthorization that supports the medical necessity and appropriateness of the treatment or services requested, such as office notes and diagnostic reports.

C. A provider may submit the request for preauthorization by mail, electronically or by fax.

R20-5-1304. Payer Denial of Request for Preauthorization

A. A payer shall not deny a request for preauthorization solely because the guidelines do not address the requested treatment or services.

B. A payer shall not deny a request for preauthorization that is supported by the guidelines, unless the payer can rebut the presumption of reasonableness and correctness with a medical or psychological opinion establishing by a preponderance of the evidence that there is a contraindication or significant medical or psychological reason not to authorize the requested treatment or services. Upon request by the provider or injured employee, a denial of preauthorization in this situation shall be processed as an immediate referral to the Commission for administrative review as provided in R20-5-1311 unless the payer obtains an IME in support of its denial. If the payer obtains an IME which serves as the basis for the denial, then review of the payer’s decision shall be processed as a request for investigation under A.R.S. § 23-1061(J) if filed by the injured employee.

R20-5-1305. Payer Denial of Payment for Provided Treatment or Services

A. A payer shall not deny payment for provided treatment or services solely because the guidelines do not address the requested treatment or services.

B. A payer shall not deny payment for provided treatment or services supported by the guidelines, unless the payer can rebut the presumption of reasonableness and correctness with a medical or psychological opinion establishing by a preponderance of the evidence that there is a medical contraindication or significant medical or psychological reason not to pay for the treatment or services.

C. A dispute related to a payer's failure to pay for provided treatment or services may be processed as a request for investigation under A.R.S. § 23-1061(J) if filed by an injured employee.

R20-5-1306. Payer Reversal of Decision to Deny Treatment or Services

A payer may reverse its decision to deny treatment or services at any time throughout the process described in this Article. In this situation, the payer's subsequent authorization or agreement to pay for the treatment or services at issue shall end this process.

R20-5-1307. Payer Decision, In Whole or In Part

A payer may issue a decision approving or denying a request for preauthorization in whole, or in part.

R20-5-1308. Failure to Comply with Required Time Limits

A payer's failure to comply with the required time limits of this process may be considered unreasonable delay under R20-5-163.

R20-5-1309. Payer Decision on Request for Preauthorization

A. Except as provided in subsections (C) or (D), a payer shall communicate to the provider its decision on a request for preauthorization no later than 7 business days after the request is received. The decision shall be issued in writing using Section II (Payer Decision on Request for Preauthorization) of the Medical Treatment Preauthorization Form approved by the Commission under R20-5-106(A)(12). A payer shall attach to the decision a statement of what has been authorized, including, if applicable, a partial authorization, and, if the request for preauthorization is denied, in whole or in part, a statement of explanation that includes the medical reason supporting the payer's decision. For purposes of this Section, the 7 business days begin to run the day after the payer receives the request.

B. If a payer fails to communicate to a provider its decision on request for preauthorization within 7 business days, then the payer's failure to take action is deemed a "no response" and the provider or injured employee may submit a request for administrative review directly to the Commission as provided in R20-5-1311.

C. If a payer receives a request for preauthorization not submitted on Section I (Provider Request for Preauthorization) of the Medical Treatment Preauthorization Form approved by the Commission under R20-5-106(A)(12) or an incomplete request for preauthorization using Section I (Provider Request for Preauthorization) of the Medical Treatment Preauthorization Form approved by the Commission under R20-5-106(A)(12), the payer shall:

1. No later than 7 business days after the request is received and identified, act on the request for preauthorization pursuant to subsection (A); or

2. No later than 7 business days after the request is received and identified, notify the provider in writing that the request for preauthorization is incomplete or, if applicable, that a request for preauthorization must be submitted on Section I (Provider Request for Preauthorization) of the Medical Treatment Preauthorization Form approved by the Commission under R20-5-106(A)(12).

D. If, no later than 7 business days after a request for preauthorization has been received, a payer provides written notice to the provider that an IME has been requested under R20-5-114 using Section II (Payer Decision on Request for Preauthorization) of the Medical Treatment Preauthorization Form approved by the Commission under R20-5-106(A)(12), then the payer's decision on a request for preauthorization shall be issued no later than 7 business days after the final IME report has been received by the payer. The payer shall provide a copy of the final IME report to the provider upon receipt of the IME report.

E. Unless the payer decision was supported by an IME or otherwise falls within subsection R20-5-1304(B), an injured employee or provider may seek reconsideration of a payer decision by submitting a written request to the payer (or review organization identified by the payer) using Section III (Provider or Employee Request for Reconsideration) of the Medical Treatment Preauthorization Form approved by the Commission under R20-5-106(A)(12). A provider shall attach to a request for reconsideration a statement of the specific reasons and justifications to support the request. If not previously provided, the injured employee or provider shall attach supporting medical documentation with the request for reconsideration.

F. An injured employee may seek review of a payer decision that is supported by an IME by requesting an investigation under A.R.S. § 23-1061(J).

G. Unless the decision was supported by an IME, an injured employee or provider may seek review of a payer decision issued under R20-5-1304(B) by requesting administrative review by the Commission as provided in R20-5-1311.

H. A payer shall provide a copy of its written decision to deny treatment or services to the injured employee or, if represented, to the injured employee's authorized representative.

R20-5-1310. Payer Reconsideration on Request for Preauthorization

A. Except as provided in subsection (C), a payer shall communicate to the provider its decision on a request for reconsideration no later than 7 business days after the request is received. This decision shall be issued in writing using Section IV (Payer Decision on Request for Reconsideration) of the Medical Treatment Preauthorization Form approved by the Commission under R20-5-106(A)(12). A payer shall attach to the decision a statement of what has been authorized, including, if applicable, a partial authorization, and, if the request for preauthorization is denied, in whole or in part, a statement of explanation that includes the

medical reason supporting the payer's decision. For purposes of this subsection, the 7 business days begin to run the day after the payer receives the request for reconsideration.

B. If a payer fails to respond to a request for reconsideration within 7 business days, the provider or injured employee may submit a request for administrative review directly to the Commission as provided in R20-5-1311.

C. If, no later than 7 business days after a request for reconsideration has been received, a payer provides written notice to the provider that an IME has been requested under R20-5-114 using Section IV (Payer Decision on Request for Reconsideration) of the Medical Treatment Preauthorization Form approved by the Commission under R20-5-106(A)(12), then the payer's decision on a request for reconsideration shall be issued no later than 7 business days after the final IME report has been received by the payer. The payer shall provide a copy of the final IME report to the provider upon receipt of the report.

D. Commission Review of Payer Reconsideration Decision:

1. An injured employee or provider may seek review of a payer reconsideration decision by requesting an administrative review by the Commission as provided in R20-5-1311 unless the payer decision was supported by an IME.

2. An injured employee may seek review of a payer reconsideration decision that is supported by an IME by requesting an investigation under A.R.S. § 23-1061(J).

E. A payer shall provide a copy of its written reconsideration decision to deny treatment or services to the injured employee or, if represented, to the injured employee's authorized representative.

R20-5-1311. Administrative Review by Commission

A. Absent further action of the Commission under R20-5-1301(C), administrative review under this Article is available for requests for medical treatment or services related to all body parts and conditions.

B. A request for administrative review shall be in writing using Section V (Provider or Employee Request for Administrative Peer Review) of the Medical Treatment Preauthorization Form approved by the Commission under R20-5-106(A)(12). A request for administrative review must attach copies of relevant medical information or records and copies of all documentation related to the payer's decision or non-response. A request for administrative review must be submitted to the Commission by mail, electronically or by fax.

C. Upon receipt of a request for administrative review, the Commission shall determine whether the administrative review is available under this Article.

1. If administrative review is not available, then no later than three business days after receiving a request for administrative review, the Commission shall send notice to the injured employee and payer that administrative review is not available.

2. If administrative review is available, then no later than three business days after receiving the request, the Commission shall send notice to the payer that a request for administrative review has been received and provide information on how to participate in the process.

D. The administrative review conducted under this Section shall apply the guidelines as described in this Article and include a peer review performed by an individual meeting the requirements of subsection (I). The peer review shall consist of a records review and, when possible as described in subsection (I)(5), a conversation between the provider and individual conducting the peer review.

E. The Commission may enter into an agreement with one or more contractors, who shall be URAC accredited, to provide the review described in subsection (D).

F. The payer shall pay for the costs of the peer review conducted by the contractor.

G. To assist in its review, the Commission or its contractor may request or receive additional information and documentation from the provider, injured employee or payer, who shall cooperate and provide the Commission or its contractor with any necessary medical information, including information pertaining to the payer's decision.

H. Before the Commission or its contractor issues a determination denying the request for treatment or services, a good faith effort shall be made to conduct a peer review with the provider requesting authorization to perform the treatment or services.

I. The individual conducting the peer review shall:

1. Hold an active, unrestricted license or certification to practice medicine or a health profession and be involved in the active practice of medicine or a health profession during the five preceding years. For purposes of this subsection, "active practice" means performing patient care for a minimum of eight hours per week in one of the five preceding years;

2. Be licensed in Arizona, unless the Commission or its contractor is unable to find such an individual, in which case the peer review may be conducted by an individual who is licensed in another state of the United States and who meets the other requirements of this subsection;

3. For a review of a request from an allopathic or osteopathic physician, nurse practitioner, physician assistant, or other mid-level provider, hold a current certification from the American Board of Medical Specialties or the American Osteopathic Association in the area or areas appropriate to the condition, procedure or treatment under review;

4. Be in the same profession and the same specialty or subspecialty as typically performs or prescribes the medical procedure or treatment requested; and

5. Make a good faith effort to contact the provider requesting the preauthorization. This good faith effort shall include making telephone contact during the provider's normal business hours and offering to schedule the peer review at a time convenient for the provider.

J. A provider may bill the payer for time spent participating in a peer review under this Section.

K. The Commission or its contractor shall issue a written determination of its administrative review that contains the name and title of the person that performed the administrative review, and includes the following information: 1. Whether the request for treatment or services is authorized or denied, in whole or in part; 2. The information reviewed; 3. The principle reason for the decision; and 4. The clinical basis and rationale for the decision.

L. An interested party dissatisfied with the administrative review determination may request that the dispute be referred to the Commission's Administrative Law Judge Division for hearing. This request for hearing shall:

1. Be in writing;

2. Filed no later than 10 business days after the administrative review determination is issued; and

3. State whether the party requests to participate in the Fast Track ALJ Dispute Resolution Program by stipulation, or declines to participate in the Fast Track ALJ Dispute Resolution Program.

M. If a timely request for hearing is filed, the administrative review determination is deemed null and void and shall serve no evidentiary purpose.

N. The information provided by the parties under this Section and the determination issued by the Commission shall become a part of the Commission claims file for the injured employee.

R20-5-1312. Hearing Process

A. A referral of a request for hearing under R20-5-1311(L) shall be processed as provided for in the Act unless all parties agree to participate in the fast track process.

B. The following applies only to the Fast Track ALJ Dispute Resolution Program:

1. Parties must agree to participate in the Fast Track ALJ Dispute Resolution Program with the understanding that a short form decision will be issued.

2. Review by the presiding ALJ shall be limited to the treatment or service dispute considered at the administrative review under R20-5-1311.

3. The presiding ALJ shall issue a notice of hearing within 10 business days of the receipt of the fully executed agreement to participate and certificate of readiness.

4. The hearing shall be held within 30 calendar days from the day that the notice of hearing is issued to the extent practicable.

5. Discovery is limited to five interrogatories and no depositions are permitted.

6. The presiding ALJ shall take all lay witness testimony at the time of the hearing and will not hold any further hearings.

7. The presiding ALJ shall consider documentary medical evidence only; no medical testimony shall be taken.

8. Medical file review opinions shall be deemed to constitute substantial evidence to support the requested treatment or service.

9. All documentary evidence shall be submitted no later than 10 business days before the scheduled hearing.

10. The hearing shall be recorded, but not transcribed, unless one or more of the parties files a request for review under A.R.S. § 23-942 and A.R.S. § 23-943.

11. The presiding ALJ shall issue a short form decision within five business days after the matter is deemed submitted.