NOTICES OF FINAL RULEMAKING

This section of the *Arizona Administrative Register* contains Notices of Final Rulemaking. Final rules have been through the regular rulemaking process as defined in the Administrative Procedures Act. These rules were either approved by the Governor's Regulatory Review Council or the Attorney General's Office. Certificates of Approval are on file with the Office.

The final published notice includes a preamble and text of the rules as filed by the agency. Economic Impact Statements are not published.

The Office of the Secretary of State is the filing office and publisher of these rules. Questions about the interpretation of the final rules should be addressed to the agency that promulgated them. Refer to Item #5 to contact the person charged with the rulemaking. The codified version of these rules will be published in the *Arizona Administrative Code*.

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

[R16-99]

PREAMBLE

1. Article, Part, and Section Affected (as applicable) — **Rulemaking Action**

Article 13	New Article
R20-5-1301	New Section
R20-5-1302	New Section
R20-5-1303	New Section
R20-5-1304	New Section
R20-5-1305	New Section
R20-5-1306	New Section
R20-5-1307	New Section
R20-5-1308	New Section
R20-5-1309	New Section
R20-5-1310	New Section
R20-5-1311	New Section
R20-5-1312	New Section

2. Citations to agency's statutory rulemaking authority to include the authorizing statute and the implementing statute:

Authorizing statute: A.R.S. § 23-107(A)(1)

Implementing statute: A.R.S. § 23-1062.03

3. The effective date of the rule:

a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):

Not applicable

b. If the agency selected a date later than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):

October 1, 2016

The Industrial Commission requests the new rules become effective on October 1, 2016. An effective date later than the 60 day effective date specified in A.R.S. § 41-1032(A) is necessary to allow the Commission to complete the infrastructure needed to apply the new rules.

4. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the proposed rule:

Notice of Rulemaking Docket Opening: 21 A.A.R. 2475, October 23, 2015

Notice of Proposed Rulemaking: 21 A.A.R. 2739, November 13, 2015

5. The agency's contact person who can answer questions about the rulemaking:

Name: Jacqueline Kurth, Manager, Medical Resource Office

Address: Industrial Commission of Arizona

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Phoenix, AZ 85007
Telephone: (602) 542-6731
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6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

Arizona Revised Statutes § 23-1062.03 requires the Industrial Commission of Arizona to develop and implement a process for the use of evidence-based medical treatment guidelines to treat injured workers within the context of Arizona's workers' compensation system. The Industrial Commission is making these rules to comply with that legislative directive. These rules, which implement a process for the use of treatment guidelines, are intended to improve the quality and outcomes of medical care, and to improve the efficiency and effectiveness of the process under which that medical care is provided to injured workers.

7. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

Not applicable

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. A summary of the economic, small business and consumer impact:

In accordance with the statutory mandate, the Industrial 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. The use of the ODG treatment guidelines is expected to reduce workers' compensation costs. For example, the impact resulting from the adoption of a closed drug formulary alone, part of the ODG treatment guidelines, is estimated to reduce overall workers' compensation costs in Arizona by $23 million during the six month period between July 1 and December 31, 2016. This component of the estimated impact used an assumed effective date for Article 13 of July 1, 2016. Even though the actual effective date is anticipated to be October 1, 2016, the estimated impact for six months is still considered valid to illustrate the impact of the use of treatment guidelines.

There will be some costs incurred by the participants in the workers' compensation system. Participants include medical providers, payers (insurance carriers and self-insured employers), attorneys, and the Industrial Commission of Arizona. All participants will use evidence-based medical treatment guidelines published by the Work Loss Data Institute and referred to as the ODG. To access the ODG guidelines, participants may purchase an annual subscription and the cost to purchase an annual subscription in 2016 ranges from $249.00 to $599.00 or participants may access the ODG using dedicated computer workstations established at the Industrial Commission at no cost to the user. The 2016 cost to the Commission for each station will be $325.00. The Industrial Commission has not yet determined how many workstations will be made available because the demand for such access cannot be accurately predicted.

The administrative review process may result in a peer review that will be conducted by a third party vendor who must be URAC accredited. URAC was originally incorporated under the name Utilization Review Accreditation Commission. That name was shortened to the acronym URAC in 1996 when it began accrediting other types of organizations such as health plans, pharmacies, and provider organizations. At present, URAC accreditations, certifications, and designations address health care management, health care operations, health plans, pharmacy quality management, and providers. The administrative review process and peer review should reduce delays in providing employees with reasonably required medical treatment, improve the processing of their workers' compensation claims, and reduce litigation time and cost. The cost for the peer review will be paid by the payer and the 2016 cost for a peer review ranges from $250.00 to $550.00 per peer review. The precise cost will depend on the complexity of the proposed medical treatment and the number of medical records involved in the peer review.

The Industrial Commission has created a Medical Resource Office (MRO) to administer the Commission's role in the administrative review process. The MRO will require an additional two staff and a program manager for a total number of three new "full time equivalent" positions. To support an efficient preauthorization process, the Commission is developing an electronic system and the estimated total cost to complete the system is $190,300.00.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

No substantial substantive changes have been made to the rules. Non-substantive grammatical, formatting, and consistency changes have been made throughout the rules. To reduce the use of "statements" in Article 13, and because describing what is included does not require also describing what is not included, the second paragraph of Rule 1301(A) has been deleted. Rule 1301(B) specifies that the guidelines shall apply to the management of chronic pain and the use of opioids in all stages of pain management and it is not necessary to include both the words "apply to" and "and are mandatory in." Accordingly, the words "and are mandatory in" have been deleted from Rule 1301(B).

As published in the Notice of Proposed Rulemaking, Rule 1310 contained two subsections "B." The second subsection "B" has been relettered to "F." The words "or its contractor" were inadvertently omitted from Rule 1311(H) and (K) (although properly included in Rules 1311(G), 1311(I)(2)). In the definition of "Peer Review" in Rule 1302, "11(I)" was inadvertently omitted from the citation to R20-5-1311(I) and has been added. References in Rule 1304, 1309 and 1310 to the "administrative review" process in Rule 1312 have been changed to reflect that the process is actually Rule 1311.

As a result of stakeholder comments, the definition of "chronic pain" has been clarified to avoid potential confusion. As published in the Notice of Proposed Rulemaking, Rule 1301(B) explained that: "For purposes of this process, chronic pain shall be defined by the guidelines." Rule 1302 also included a definition of chronic pain: "means any pain that persists beyond the anticipated time of healing." Because the guidelines contain a definition for chronic pain, it is not necessary to also include a definition in Rule 1302. Accordingly, the superfluous inclusion of a definition of chronic pain in Rule 1302 has been deleted. The incorrect reference to Rule 1301(F) in the definition of "Applicability" in Rule 1302 has been corrected to Rule 1301(B) and (C). The incorrect reference to Rule 1314(B) in the definition of "Fast Track ALJ Dispute Resolution Program" in Rule 1302 has been corrected to 1312(B).

11. Any agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

The Commission received five written comments related to the proposed rulemaking from the following: Property Casualty Insurers (PCI), Arizona Association of Lawyers for Injured Workers (AALIW), Healthesystems, CopperPoint Mutual Insurance Company, and the Arizona Self-Insurers Association (ASIA). The Industrial Commission held an oral proceeding regarding the proposed rules on December 15, 2015. Representatives of three stakeholders spoke at the Oral Proceeding. Those three stakeholders were, CopperPoint Mutual Insurance, AALIW, and Coventry/CompPharma. The comments pertaining to each rule are addressed in order:

Rule 1301 Adoption and Applicability of the Article

Comment: Property Casualty Insurers (PCI) supports the adoption of the *Official Disability Guidelines* (ODG) as evidence-based guidelines for chronic pain and opioid treatment. PCI has stated that the adoption of the ODG should not be limited to the management of chronic pain and the use of opioids for all stages of pain management. PCI would like the Industrial Commission of Arizona (ICA) to utilize ODG for all medical care delivered under the Arizona Workers Compensation Act. Written comments from PCI 12/01/2015.

Response: A.R.S. § 23-1062.03 directs the Commission to develop and implement a process for the use of evidence-based medical treatment guidelines, where appropriate, to treat injured workers. In compliance with the statutory directive, the Commission has already adopted the ODG. Although the Commission has specified that the use of the ODG is limited to management of chronic pain and the use of opioids for all stages of pain management, the Commission recognizes that the application of the use of the ODG to treat injured workers may be expanded and Rule 1301(C) provides for this possibility.

Rule 1301(B) Adoption and Applicability of the Article

Comment: AALIW suggests the rule read, "Until further action of the Commission, the guidelines shall apply only to and are mandatory only in the management of chronic pain and the use of opioids for chronic pain management." AALIW would like to change the language in the proposed rule so that the rule would apply the guidelines only to management of chronic pain and the use of opioids for chronic pain management as opposed to applying the use of opioids to all stages of pain management. Written comments from AALIW 12/11/2015 were the same comments made at Oral Proceeding 12/15/2015.

Response: The Commission's adoption of the ODG and the initial scope of the use of the ODG results from consensus recommendations produced by the Advisory Committee for Evidence Based Medical Treatment Guidelines (Director's Advisory Committee). This committee of community stakeholders included medical doctors, attorneys who represent injured workers, payers, attorneys who represent payers and Industrial Commission staff. The Commission has adopted the consensus recommendations. One of those recommendations was for the ODG to initially apply to the management of chronic pain and the use of opioids for all stages of pain management. The Commission continues to consider this appropriate.

Comment: Healthesystems commented that the rules should be mandatory for the management of treatment of chronic pain and the use of opioids for all stages of pain management, and presumably "all stages" includes the initial onset. This would imply that the entire ODG would be applicable to any injury where there is a pain management component. Managing pain often involves prescribing medications that are not opioids but generate requests for preauthorization and may not be appropriate for an injured worker's treatment plan. For this reason, whether Appendix A, closed formulary, is included should be clarified. Written comments from Healthesystems 12/14/2015.

Arizona Self-Insured Association (ASIA) views limiting the rules to chronic pain as an important first step, and continue to support the expansion of the rules to all injuries so all claims, injured workers, and employers are treated equally under the rules. Written comments from ASIA 12/15/2015.
Response: The Commission's adoption of the ODG and the initial scope of the use of the ODG results from consensus recommendations produced by the Director's Advisory Committee. The consensus recommendations did not include the use of the word "only" and the Commission does not consider it necessary nor desirable to use the word "only" in Rule 1301(B) as doing so may create confusion between Rule 1301(B) and 1301(C). Likewise, the Commission's adoption of the consensus recommendation was to apply the ODG to the use of opioids for all stages of pain management. Appendix A is part of the ODG treatment guidelines.

Rule 1301(C) Adoption and Applicability of the Article
Comment: AALIW would like the Commission to limit the applicability of the treatment guidelines for at least two years after implementation of these rules. "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 1) will improve medical treatment for injured workers, 2) will make treatment and claims processing more efficient and cost effective, and 3) where the guidelines provide adequate coverage of the body parts or conditions." AALIW also commented that a sentence should be added to the end of Rule 1301(C) as follows: "Such action may only be taken after sufficient time has passed to evaluate the effect of the current applicability on the provision of appropriate medical care. Sufficient time shall be at least two (2) years after the implementation of these rules."
Response: Neither the Director's Advisory Committee's consensus recommendations nor the Commission's adoption of the consensus recommendations include any time period limitation. Rule 1301(C) requires the Commission provide the public with the opportunity to comment and hold a public hearing before the Commission may take action to modify or change the applicability of the guidelines.

1302 Definitions
Comment: AALIW believes the definition of "Chronic Pain" as "any pain that persists beyond the anticipated time of healing" is extremely vague and subject to a wide range of interpretation. To add solidity to the definition, AALIW suggests the following change be made to the definition of Chronic Pain: "intermittent in addition to continuous, namely that it has persisted for at least three months and has resulted in pain on at least half the days in the past six months." Additionally, AALIW suggests adding "has persisted for at least three months after the original injury or any surgery" to make clearer that the issue addressed is chronic pain rather than acute pain.
Response: Both the Director's Advisory Committee and the Commission, when it adopted the Committee's recommendations, intended for the definition of chronic pain to be the definition as contained in the guidelines (as noted in Rule 1301(A)). To avoid any confusion with the unnecessary definition of chronic pain that was in Rule 1302, that definition has been deleted.

Rule 1303 et seq. Provider Request for Preauthorization
Comment: PCI comment: It is critical that the preauthorization process be utilized to ensure that there is proper medical basis for departing from the guidelines before the injured worker receives that treatment in order to avoid unnecessary chemical dependency or addiction. The legislative directive to the Commission found in A.R.S. § 23-1062.03 is broad enough to include a mandatory preauthorization process adopted by the Commission for the use of evidence-based medical treatment guidelines. The rules should include the following: "No preauthorization is required to ensure payment for reasonably required medical treatment or services supported by the adopted guidelines. Preauthorization is required for all medical treatment or services that are not supported by the adopted guidelines or are not addressed by the adopted guidelines."
Response: Assuming the Commission has the authority to impose a mandatory preauthorization process, the Commission has elected not to do so at this time.

Rule 1304 Payer Denial of Request for Preauthorization
Comment: AALIW states that nothing in these new rules overcomes the requirements of A.R.S. § 23-1062.02(F), which requires that, when there is a conflict on the need for opioids, the payer is to provide drug rehabilitation and detoxification treatment. In the event of a dispute regarding the need for rehabilitation and detoxification, the payer

must continue to provide the opioids until a determination is made after a hearing by an administrative law judge.
Response: The rules do not override A.R.S. § 23-1062.02(F).

Rule 1304(B) Payer Denial of Request for Preauthorization
Comment: AALIW believes this rule is at odds with Rule 1309(B) in that it requires a payer to provide a great deal of information if they deny preauthorization for treatment that is supported by the guidelines, but Rule 1309(B) allows them to simply ignore the request.
Response: This comment mischaracterizes Rule 1309(B) as allowing a payer to "ignore" a request. The rule provides the payer with a time-frame for communicating its decision regarding a request for preauthorization and if a payer does not communicate its decision within the specified time-frame, provides the provider and injured employee with the ability to seek administrative review.

Rule 1309(D) Payer Decision of Request for Preauthorization
Comment: AALIW suggest changes to eliminate "final" IME as they believe the provider and the applicant should be privy to all of the doctor's reports as they become available. The following is the suggested change to the rule: "If, no later than 10 business days after a request for preauthorization has been received, a payer provides notice to the provider that an IME has been requested under R20-5-114, then the payer's decision on a request for preauthorization shall be issued no later than 10 business days after the IME report has been received by the payer. The payer shall provide a copy of the IME report to the provider immediately upon receipt of the IME report. The IME must be scheduled to occur within 45 days of the receipt of the request for preauthorization. The report shall be provided within 10 days of the examination."
Response: The comment appears to be directed at obtaining preliminary written communications from IME doctors even in those circumstances where the preliminary "report" has no impact on the decision. This may occur, for example, when an IME doctor communicates to the payer that an IME clinical examination has been completed but the doctor is waiting for results from an MRI before rendering an opinion. In those circumstances where the IME doctor agrees with the attending physician and preauthorization is approved, requiring the payer to supply all the preliminary written communications would not appear to be an efficient and effective use of resources. Given that the preauthorization process is intended to be an efficient and effective process with minimal extraneous requirements, it does not appear appropriate to require a payer to supply this type of written communication as part of the preauthorization process. The rules do not have any impact on the parties' ability to obtain such medical records during the course of discovery should a workers' compensation claim involve litigation.

Rule 1309(H)(6)(c) Payer Decision of Request for Preauthorization
Comment: AALIW suggest adding "the applicant or their representative," to the sentence that begins "The provider shall file this request . . ." so the beginning of the sentence would read: "The provider, the applicant or their representative, shall file this request . . . ."
Response: The process described in Rule 1309(H)(6)(c) is intended to provide a process for a provider to request the payer review a decision that is issued without an IME and the intent was to limit the initiation of this particular process to the provider.

Rule 1309(I) Payer Decision of Request for Preauthorization
Comment: AALIW suggest adding "or their representative" to the following sentence: "A payer shall provide a copy of its written decision to deny treatment or services to the injured employee." so it would read: "A payer shall provide a copy of its written decision to deny treatment or services to the injured employee or their representative."
Response: It is a common practice for payers to communicate with attorneys, rather than directly with the injured employee, in those circumstances where an injured employee is represented by an attorney and the attorney has notified the payer of the representation and has requested that the payer communicate with the attorney. Because it is a common practice, payers are expected to continue to communicate with attorneys and it does not appear necessary to include such a requirement in Rule 1309(I).
Additional Response: Under existing rules, A.A.C. R20-5-102 and A.A.C. R20-5-158, an individual authorized by law to act on behalf of an injured employee who has provided written notice of this authorization to the Commission must be served on all awards, decisions, orders, notices, documents or other matters as required by law. While it does not appear necessary to include additional language in Rule 1309(I), the Commission agrees that adding "or authorized representative" to the end of this subsection would be a non-substantive change.

Rule 1310(C) Payer Reconsideration of Request for Preauthorization
Comment: AALIW suggest changing "Final IME" to "IME" and recommends an additional two sentences be added to the proposed rule as follows: "If, no later than 10 business days after a request for reconsideration has been received, a payer provides notice to the provider that an IME has been requested under R20-5-114, then the payer's decision on a request for reconsideration shall be issued no later than 10 business days after the IME report has been

received by the payer. The payer shall provide a copy of the IME report to the provider immediately upon receipt of the IME report. The IME must be scheduled within 45 days of receipt of the request for preauthorization. The report shall be provided within 10 days of the examination."
Response: The rule, as drafted, adequately describes the process.
Additional Response: If a preliminary IME report provides sufficient information for a payer to make a decision regarding preauthorization, then the payer should notify the medical provider and the injured employee of the preauthorization decision within 10 business days from the receipt of the preliminary report. However, it is not uncommon for IME physicians to request additional information, including diagnostic testing, prior to finalizing their IME reports which can result in different opinions and recommendations than those set forth in preliminary reports. Therefore, it is recommended that the preauthorization decision be communicated to the medical provider and the injured employee within 10 business days from the receipt of the final IME report unless the preliminary IME report provides the payer with sufficient information to make a decision regarding a preauthorization request.

Rule 1310(B) Payer Reconsideration of Request for Preauthorization
Comment: AALIW identified a possible typographical error in that the second subsection identified as "B" in Rule 1310 should be "F." In 1310(E)(6)(a), AALIW suggest adding "the applicant or their representative" to the sentence that begins "The provider shall file this request . . . ." so the sentence would read: "The provider, the applicant or their representative, shall file this request. . . ."
Response: The second use of "B" is a typographical error and has been corrected. In those circumstances where an injured employee is represented by an attorney, that attorney may submit a request for administrative review on behalf of the injured employee.

Rule 1311(A) Administrative Review by Commission
Comment: AALIW recommends restricting application of the rule to chronic pain management and to not apply the rule to the use of opioids to all stages of pain management. AALIW suggest making the following changes to the rule: "Until further action of the Commission under R20-5-1301 (C), administrative review under this Article is limited to requests for medical treatment or services related to the management of chronic pain or the use of opioids for chronic pain management."
Response: The intent is for the ODG treatment guidelines to apply to the use of opioids for all stages of pain management.

Rule 1311(I)(1) Administrative Review by Commission
Comment: AALIW recommends changes to the requirements for the individual conducting the peer review from performing patient care for a minimum of 8 hours per week in one of the five preceding years to at least three of the five preceding years. The recommended changes are as follows: "Hold an active, unrestricted license or certification to practice medicine or health profession during the 5 preceding years. For purposes of this subsection, "active practice" means performing patient care for a minimum of 8 hours per week in at least three of the five preceding years;"
Response: The suggested amendment imposes an unnecessary restriction on those physicians who may perform peer reviews. As drafted, the rule provides for an appropriate practice requirement.

General Comments:
The following general comments, A through E, were received from Healthesystems 12/14/2015;
Comment: A. Scope and Applicability of the ODG and Appendix A; Closed Formulary. Review of the draft is unclear as to the applicability of the ODG Appendix A, closed formulary. If the intent is to set a standard of care for all injury types where pain management is a component of care, then the ODG could be broadly applied to all claims and all injury types where the patient's symptoms include acute or chronic pain.
Response: The Commission adopted the ODG which includes Appendix A, ODG Workers' Compensation Drug Formulary for the management of chronic pain and the use of opiates for all stages of pain management.
Comment: B. How Pharmacy Benefit Managers Factor into the Process. Payers use pharmacy benefit managers (PBM) to identify medications which are appropriate for additional screening. Pharmacies are equipped to communicate in real time with payers through the payers' PBMs. The entire transaction from pharmacist to payer for approval response takes a fraction of a second to complete. Some medications, including opioids and non-opioid drug classes cannot be immediately substantiated as casually related or appropriate by the available medical evidence. This may cause authorization to take longer, but most requests take only a few minutes or hours, not days, to get a payer decision.
Comment: C. This real time connectivity between the pharmacy and the PBM eliminates the need for paper forms being sent back and forth between these entities. Most pharmacies and PBMs are connected via electronic "switches "using nationally adopted standardized formats. Pharmacists should not be required to use the MRO-1 Preauthorization Form as paper forms are rarely used by pharmacists. Healthesystems recommends consolidating

the MRO-1 Form and the MRO-2 Form into a single form, where the payer can respond on the bottom of the request.
Response: The Medical Resource Office (MRO) is developing an electronic system for those who wish to request preauthorization. The MRO process is not intended to replace or displace forms that providers may use to communicate with vendors (such as PBMs), with other providers, or with payers.
Additional Response: Use of the MRO-1 Request for Preauthorization Form is to be used by medical providers (prescribers) and payers and is not intended for use by pharmacies and PBMs.

Comment: D. Commission education and support for the community. Healthesystems recommends the Commission provide educational support to providers, payers and the injured worker community. Training may include classroom, online webinars or web based resources as well as Frequently Asked Questions (FAQs).
Response: The Industrial Commission has made training available to the public on how to use the ODG treatment guidelines by offering multiple workshops at the Commission's Annual Claims Seminar held in August 2015 and the Commission's website, www.azica.gov, has links to ODG webinars, FAQs about ODG and MRO forms for participation in the treatment guidelines process. When the Rules are finalized, the Commission will offer training workshops online and at the Commission on how to use the treatment guidelines and the process for administrative review.

Comment: E. Applicability of the formulary. Healthesystems suggest clarification as to the applicability of the formulary within the rule. If Appendix A closed formulary of ODG is not adopted, then we suggest it be specifically excluded as per the other exclusions in Rule 1301. If Appendix A closed formulary is adopted, in part for opioids only, or in whole, we suggest the Commission also incorporate language which specifies that to avoid confusion by payers, medical providers and injured workers.
Response: The Commission has adopted Work Loss Data Institute's *Official Disability Guidelines* (ODG) Treatment Guidelines which includes Appendix A, Workers' Compensation Drug Formulary for management of chronic pain and the use of opioids for all stages of pain management.
Additional Response: Appendix A, ODG Workers' Compensation Drug Formulary, has been adopted in whole by the Industrial Commission and will apply to all medications prescribed for the management of chronic pain and the use of opioids for all stages of pain management.

The following general comments, A through H, were received from CopperPoint Mutual Insurance Company on December 15, 2015 and were the same as the comments presented at the Oral Proceeding held on December 15, 2015:

Comment: A. National Council on Compensation Insurance (NCCI) report on Arizona medical cost. CopperPoint cites the following statistics from NCCI Medical Data Report for the state of Arizona September 2015: medical benefits represent 76% of total benefit cost which compares unfavorably to 64% for the Region (CO, NV, NM and UT) and 59% when looking at Countrywide. NCCI reports distribution of Arizona drug dollars at 13% while both the Region and Countrywide are reported to be 11%.
Comment: B. Adoption of Article 13. CopperPoint fully supports adoption of these rules.
Comment: C. Proposed Rule. CopperPoint comments that the proposed rule is a culmination of several years' work by highly respected individuals within the Arizona workers' compensation community. Hours of research were undertaken to investigate solutions to a real, shared problem – chronic pain and the use of opioid medications across all injuries. Litigation for these types of cases can be protracted and lengthy, resulting in treatment being delayed and debated for well over a year. The ultimate decision is not medically based but the course of care is determined by an administrative law judge.
Comment: D. Official Disability Guidelines (ODG). CopperPoint concurs that the ODG published by the Work Loss Data Institute are the most comprehensive, user friendly and most appropriate for Arizona. They point out that nationally other workers' compensation jurisdictions have successfully been using evidence-based guidelines for years.
Comment: E. Preauthorization Request Form (MRO-1). CopperPoint suggests making the use of the MRO-1 Form mandatory to expedite recognition of a Provider Request for Preauthorization by a Payer, which would allow for appropriate processing for a timely response of the covered request by the payer. Experience from other jurisdictions indicates a vast majority of preauthorization requests are approved.
Comment: F. Administrative Review Process by Commission. Different opinions will be adequately resolved via the Administrative Review Process at the Commission through utilization of an independent peer review process. The requesting physician will have an opportunity to explain a requested deviation from the ODG to a similarly credentialed peer physician reviewer.
Comment: G. Fast Track Hearing Process. CopperPoint believes this process provides an opportunity to expedite a litigate dispute thereby eliminating the delay in treatment for the injured worker.

Comment: H. Expansion of the use of evidence-based medicine. CopperPoint urges the Commission to expand evidence-based medicine to all conditions 6 months after implementation of the Rule. Further delay in the expansion of evidence-based medicine will not adequately resolve the issues intended by implementation of this enhancement to our system.
Response: With respect to item E, neither the use of the preauthorization process or the "forms" within the electronic process are mandatory. With respect to item H, neither the Director's Advisory Committee's consensus recommendations nor the Commission's adoption of the consensus recommendations include any specific time period for the Commission to consider expanding the scope of the use of the treatment guidelines and the Commission is not able to predict when, or if, the scope will be expanded. The remaining comments seem to support the rulemaking and the Commission appreciates this support.

The following general comments, A through C, were received from ASIA 12/15/2015:
Comment: A. Strongly supports the Industrial Commission effort to implement evidence-based medicine treatment standards for Arizona's Workers' Compensation System.
Comment: B. Believes the original intent of A.R.S. § 23-1062.03 was to implement evidence-based guidelines for a broader range of workers' compensation injuries. By segregating the rules to apply to only one type of condition, the proposed rules create a disparity of treatment with injured workers who have sustained other conditions that may also benefit from the preauthorization and peer review processes.
Comment: C. Supports the remaining language outlining the process for evidence-based medicine
Response: A.R.S. § 23-1062.03 directs the Commission to develop and implement a process for the use of evidence-based medical treatment guidelines, where appropriate, to treat injured workers. In compliance with the statutory directive, the Commission has already adopted the ODG. Although the Commission has specified that the use of the ODG is limited to management of chronic pain and the use of opioids for all stages of pain management, the Commission recognizes that the application of the use of the ODG to treat injured workers may be expanded and Rule 1301(C) provides for this possibility.

The following general comments, A through D, were received from Coventry Health Care and CompPharma at the Oral Proceeding held 12/15/2015:
Comment: A. Supports across the board the adoption of treatment guidelines and recommendations by the Commission.
Comment: B. Requests clarification regarding preauthorization. There is no language that says preauthorization is required if treatment is not located within the treatment guidelines. They recommend a slight addendum to the language.
Comment: C. Asserts that the current definition of chronic pain leaves it open to interpretation regarding whose definition is accepted: Provider? Prescriber? Payer? Injured Worker? Having a more concrete definition will ease everybody's burden as we put this into practice.
Comment: D. Suggests it is not clear what part of *Official Disability Guidelines* (ODG) will be adopted. Specifically, they would like to understand if Appendix A in the ODG, Drug Formulary, which includes multiple classes of medications, including narcotics and opioids, is adopted. They would like to ensure that for all of the Pharmacy Benefit Managers (PBMs) that covered lives continue to either get delivery of medications or people get into appropriate weaning practices. They would like to educate people in terms of how the process is going to work from all sides. As currently written guidelines versus practicality, they believe it is open-ended and would make it difficult to put things in a workflow process so that they (Coventry/CompPharma) know if they are adhering to guidelines. But generally speaking, they are very supportive of treatment guidelines.
Response: With respect to item B, the Arizona workers' compensation act does not require preauthorization and, assuming the Commission has the authority to impose mandatory preauthorization, the Commission has elected not to do so at this time. With respect to item C, the term "Chronic Pain" is defined by the ODG. With respect to item D, the Commission has adopted Work Loss Data Institute's *Official Disability Guidelines* (ODG) Treatment Guidelines which includes Appendix A, Workers' Compensation Drug Formulary for management of chronic pain and the use of opioids for all stages of pain management. The Commission appreciates the support for the rulemaking.

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

The rule does not require a permit.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than the federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

Not applicable

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness

of business in this state to the impact on business in other states:
No analysis was submitted.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rule:
None

14. Whether the rule was previously made, amended, repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also the agency shall state where the text changed between the emergency and the final rulemaking packages:
Not applicable

15. The full text of the rules follows:

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. THE INDUSTRIAL COMMISSION OF ARIZONA

ARTICLE 13. TREATMENT GUIDELINES

Section

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 the management of chronic pain and the use of opioids for all stages of pain management. For purposes of this process, chronic pain shall be defined by the guidelines.

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) the guidelines adequately cover the 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 shall apply to medical treatment or services occurring on or after the effective date of this Article.

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, unless the context otherwise requires:

"Act" means the Arizona Workers' Compensation Act, A.R.S. Title 23, Ch. 6, Articles 1 through 11.

"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 that has been denied or partially denied by a payer. 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 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 a request 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" or "TPA" 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, which shall include the following information:

1. Patient information (including date of injury, date of birth, and payer claim number);
2. Diagnosis and ICD code;
3. Date of request;
4. Type of request - Initial, Routine, Urgent, or Life Threatening;
5. A statement of the treatment or services requested. Where appropriate, information about quantity, strength, duration and frequency of the treatment or services should be included. Use of the applicable codes should also be included and will facilitate the process; and
6. Documentation, if not already provided, 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 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 subsection (D), a payer shall communicate to the provider its decision on a request for preauthorization no later than 10 business days after the request is received. This decision shall comply with the requirements set forth in subsection (H). For purposes of this Section, the 10 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 10 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 that fails to meet the requirements of R20-5-1303, the payer may, in its discretion:
1. Act on the incomplete request for preauthorization; or
2. No later than 10 business days after the request is received, notify the provider that the request for preauthorization is incomplete.

D. If, no later than 10 business days after a request for preauthorization has been received, a payer provides notice to the provider that an IME has been requested under R20-5-114, then the payer's decision on a request for preauthorization shall be issued no later than 10 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) that states the specific reasons and justifications to support the request. If not previously provided, the injured employee or provider shall include supporting medical documentation with their written request.

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 include the following information in its written decision to approve or deny, in whole or in part, the request for preauthorization to provide treatment or services:
1. The date on which the request for preauthorization was received;
2. Patient information, including date of injury, date of birth, payer claim number and Commission claim number;
3. The date on which an IME was completed, if applicable;
4. A statement of what has been authorized, including if applicable, a partial authorization;

5. A statement of explanation if the request for preauthorization is denied, in whole or in part, which should include the medical reason supporting the payer's decision;
6. A statement of the process under which a provider or injured employee may request reconsideration or review of the payer's denial, in whole or in part, of a request for preauthorization, which shall include the following information;
   a. For a decision that is issued without obtaining an IME that is not subject to R20-5-1304(B):
      "If you wish to request reconsideration of the decision regarding your request for preauthorization to provide treatment or services, you must send a written request for reconsideration to:
         Name of Payer or Review Organization Identified by Payer
         Commission Address
         Phone
         Fax
         E-mail
      You must include the specific reason and justification to support your request. Please include additional supporting medical documentation if not previously provided."
   b. For a decision that is supported by an IME:
      "If you wish review of the decision regarding your request for preauthorization to provide treatment or services, then the injured employee is required to file a request for investigation under A.R.S. § 23-1061(J)."
   c. For a decision that is issued without obtaining an IME that is subject to R20-5-1304(B):
      "If you disagree with this decision and wish to request review by the Industrial Commission of Arizona, then you may submit a request for administrative review under R20-5-1311 to:
         Industrial Commission of Arizona
         Attn: Medical Resource Office
         Commission Address
         Commission Telephone Number
      The provider shall file this request promptly and include the following information: patient information, including name, address, payer claim number, Commission claim number, and date of injury; diagnosis or ICD code; employer, insurance carrier or TPA information; provider information; information pertaining to request for treatment, including the justification for treatment; applicable treatment guideline or guidelines; denial of treatment by payer; copies of relevant medical information or records; and whether the request for medical treatment or services involves a request for urgent care or a life-threatening condition."

I. A payer shall provide a copy of its written decision to deny treatment or services to the injured employee.

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 10 business days after the request is received. This decision shall comply with the requirements set forth in subsection (E). For purposes of this subsection, the 10 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 10 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 10 business days after a request for reconsideration has been received, a payer provides notice to the provider that an IME has been requested under R20-5-114, then the payer's decision on a request for reconsideration shall be issued no later than 10 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 include the following information in its written decision to approve or deny, in whole or in part, a request for reconsideration of a denial of preauthorization:
1. The date on which the request for reconsideration was received;
2. Patient information, including date of injury, date of birth, payer claim number and Commission claim number;
3. The date on which an IME was completed, if applicable;
4. A statement of what has been authorized including, if applicable, a partial authorization;
5. A statement of explanation if the request for treatment is denied, in whole or in part; and
6. A statement of the process under which a provider or injured employee may request Commission review of the payer's denial, in whole or in part, of a request for preauthorization, which shall include the following information:
   a. For a reconsideration decision that is issued without obtaining an IME:
      "If you disagree with this reconsideration decision and wish to request review by the Commission, then you may submit a request for administrative review under R20-5-1311 to:
         Industrial Commission of Arizona

Attn: Medical Resource Office
Commission Address
Commission Telephone Number.

The provider shall file this request promptly and include the following information: patient information, including name, address, payer claim number, Commission claim number, and date of injury; diagnosis or ICD code; employer, insurance carrier or TPA information; provider information; information pertaining to request for treatment, including the justification for treatment; applicable treatment guideline and denial of treatment by payer; copies of relevant medical information or records; copies of relevant documentation related to the payer reconsideration decision; and whether the request for medical treatment or services involves a request for urgent care or a life-threatening condition."

b. For reconsideration of a decision that is supported by an IME:

"If you disagree with this reconsideration decision and wish review by the Commission, then the injured employee is required to file a request for investigation under A.R.S. § 23-1061(J)."

F. A payer shall provide a copy of its written reconsideration decision to deny treatment or services to the injured employee.

R20-5-1311. Administrative Review by Commission

A. Until further action of the Commission under R20-5-1301(C), administrative review under this Article is limited to requests for medical treatment or services related to the management of chronic pain and the use of opioids for all stages of pain management.

B. A request for administrative review shall be in writing and submitted by mail, electronically or by fax. The request shall include the following information:

1. Identifying information of the injured employee and claim, including the injured employee's name, address, commission claim number, and date of injury;
2. Diagnosis and ICD code;
3. Identifying information of the employer, insurance carrier or TPA;
4. Identifying information of the provider;
5. Information pertaining to request for treatment, such as the justification for treatment, applicable treatment guideline and, if applicable, the payer's denial of treatment;
6. Copies of relevant medical information or records;
7. Copies of documentation related to the payer's decision or non-response; and
8. Whether the request for medical treatment or services involves a request for urgent care or a life-threatening condition.

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.