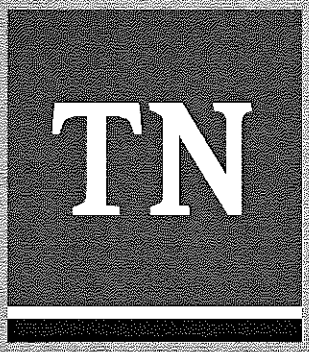
Tennessee Workers' Compensation Data Calendar Years 2009-2016

A Report of Statewide Data for the
Tennessee Advisory Council on Workers' Compensation

August 2016



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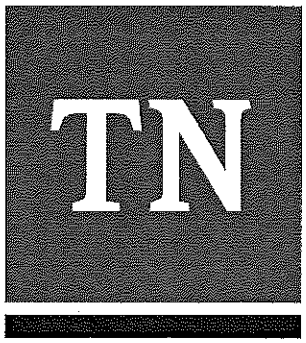
David Wilstermann



Tennessee Workers' Compensation Data
Calendar Years 2009-2016

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Data Summary

- 2016 marks the first year post the 2013 Reform Act where there were more permanent injury cases concluded with dates of injuries after the implementation of the 2013 Reform Act than before. There were 6,073 cases with dates of injuries after implementation and 1,568 cases with dates of injuries before.

- Due to the 2013 Reform Act being implemented on July 1, 2014, pre act case durations have to be at least a year and a half long, while post act cases cannot be more than two and a half years long. Even though there is overlap, this increases the likelihood of pre act cases being inherently more complicated, and involving more serious injuries.

- The median number of weeks from injury to conclusion for 2016 post act cases was 52 weeks. For 2016 pre act cases, the median case duration was 142 weeks.

- The median number of weeks from the date of maximum medical improvement to the date of conclusion was 30 weeks for 2016 post act cases and 79 for 2016 pre act cases.

- The median age of injured workers in cases with permanent disability ranged from 46 to 48 years old for all years analyzed.

- The percent of injured workers with more than a high school education increased to nearly 31% for 2016 post act cases. The percent of injured workers with a high school or high school equivalent level of education remained 58% for 2016 pre act cases.

- The median compensation rate for injured workers for 2016 post act cases was $456, up $5 from 2015. The median pre act compensation rate for 2016 pre act cases was $427.

- The median number of weeks of TTD benefits for 2016 post act cases increased to 13. The median number of weeks of temporary total benefits increased to 38.5 for 2016 pre act cases.

- The median permanent impairment ratings for injured workers who returned to pre injury employment for 2016 post act cases was 3.0. PPI ratings include body as a whole and scheduled member injuries converted to body as a whole impairment percentages.

- Permanent partial disability amounts for injured workers who returned to pre injury employment was 2.5 for 2016 post act cases, up from 2.0 in 2015.

- The median PPD multiplier for all post act cases was 1.0.

- The 2016 post act median PPD benefit amount for cases where injured workers were returned to work was $5,444. For 2016 pre act cases the median PPD benefit amount increased by more than $5,000 to $15,499.

- For 2016 post act cases, the median amount paid for medical benefits where the injured worker returned to work was $12,384. The median amount of medical benefits paid for return to work cases increased to $25,646 for 2016 pre act cases.

- For 2016 post act cases where injured workers were not returned to pre injury employment, the median PPI rating was 4.0. For 2016 pre act cases, the median PPI rating was 18.2.

- The median PPD amounts paid for cases where injured workers were not returned to pre injury employment were $8,400 for 2016 post act cases.

- The median amount paid for non return to work medical benefits was $18,301 for 2016 post act cases.

- The median amount of lump sum payments for 2016 post act cases was $4,879.

- According to information given at the time of conclusion, medical and permanent partial disability benefits comprised between 85% and 88% of the total systemic benefits paid for cases involving permanent disability.

- Missing case information from SD-1 forms remains an issue, however, the implementation of a revised statistical data form should simplify data collection, increasing the likelihood of more complete data being available.

Introduction

This snapshot of 2016 Tennessee workers' compensation cases builds on previous Advisory Council on Workers' Compensation statistical reports. 2016 remains a transition year for the implementation of the 2013 Reform Act. The first post reform act cases starting showing up in 2014 in small numbers. For 2016, cases that have dates of injury after the implementation of the reform act outnumber those from before for the first time. Throughout this report, cases with dates of injury after July 1, 2014, will be referred to as post act cases. Those with dates of injury before July 1, 2014 will be referred to as pre act. Because 2016 pre act cases have dates of injury at least a year and a half before their subsequent dates of conclusion, pre act cases are inherently longer. Associated factors with longer case lengths are higher temporary total disability amounts and more severe injuries resulting in higher permanent partial impairment and disability amounts. The 2016 pre and post act data reflect this reality. While a clearer picture of post reform data is starting to emerge, it is still too early to draw systemic conclusions. However, as identified in last year's report, the systemic data reflects what would be expected, which provides validity to what is being collected and reported on.

To continue reporting standards established in the last two reports, body as a whole and scheduled member injuries were grouped together. The Reform Act considers all impairments as impairments to the body as a whole, therefore pre act impairments and disability amounts have been converted to corresponding body as a whole amounts. Additionally, it was determined that greater emphasis will be placed on the median, which will provide a more accurate picture of the typical workers' compensation case experience. Median amounts or percentages are presented graphically to the right of or below the tables, below the descriptive text for the variables analyzed.

Methods

Pursuant to Tennessee statute, participants in the Tennessee workers' compensation system are required to send certain reports to the Tennessee Bureau of Workers' Compensation, formerly the Workers' Compensation Division. One of the final reports received by the Division/Bureau is the Statistical Data Form (SD-1). It is the closing document for a claim in which a permanent injury was sustained. The Bureau operates an integrated computer system which is referred to as the Workers' Compensation Computer System (WCS). It is into this database that the information from the SD-1 forms are entered. The Bureau provided, at the request of the Advisory Council on Workers' Compensation, data from the WCS.

Because it is necessary to have adequate time to obtain a representative collection of closed case information for analysis and pre/post act comparisons, cases were selected with dates of conclusion between January 1, 2009 and December 31, 2016. Some of the cases presented multiple conclusion dates coinciding with the various venues in which cases can be finalized. This is possible because a case may be reconsidered if, for example, changes in the injured employee's work status occur. It is impossible from a data perspective to piece back together what information translates to which conclusion, therefore cases with multiple conclusion dates

were excluded from this report, with two exceptions. There were some Division[1] offices that did not have a Workers' Compensation Specialist 4 present to approve settlements at the time of agreement. In this situation, the parties needed court approval for their case to be finalized, thus creating a Division approval date and a court approval date in close proximity. To include cases of this nature, cases with court approval dates and Division approval dates within 30 days of each other were included and coded as Division approved settlements. The other case of dual conclusion date inclusion in analysis was when a joint petition settlement and a court approved settlement were within 30 days of each other.

Until the Reform Act, permanent impairment and disability in Tennessee were split between scheduled members and the body as whole (BAW). Under the Reform Act, all impairment and disability are calculated based on the impact to the body as whole. To aid in future comparisons, pre act cases have been converted to BAW impairments and disabilities. Permanent partial impairment ratings were converted using the AMA guides and permanent partial disability amounts were converted using the reported permanent partial disability amount multiplied by the ratio of the pre act scheduled member number of weeks of benefits to the pre act body as whole number of weeks of benefits.

Conclusion Types

Pre reform act workers' compensation cases could be concluded in four ways, by trial, joint petition settlement, Workers' Compensation Division approved settlement (now Bureau of Workers' Compensation), and by court approved settlement. The following charts depict the frequency and percent in which the various conclusion types were utilized. The conclusion types were determined by the conclusion type date field that was indicated on SD-1 forms. Cases were excluded if they contained more than one conclusion type date. However, as mentioned in the methods section, cases with both court and Division approved settlements within 30 days of each other or joint petition settlements and court approved settlements within 30 days of each other were included.

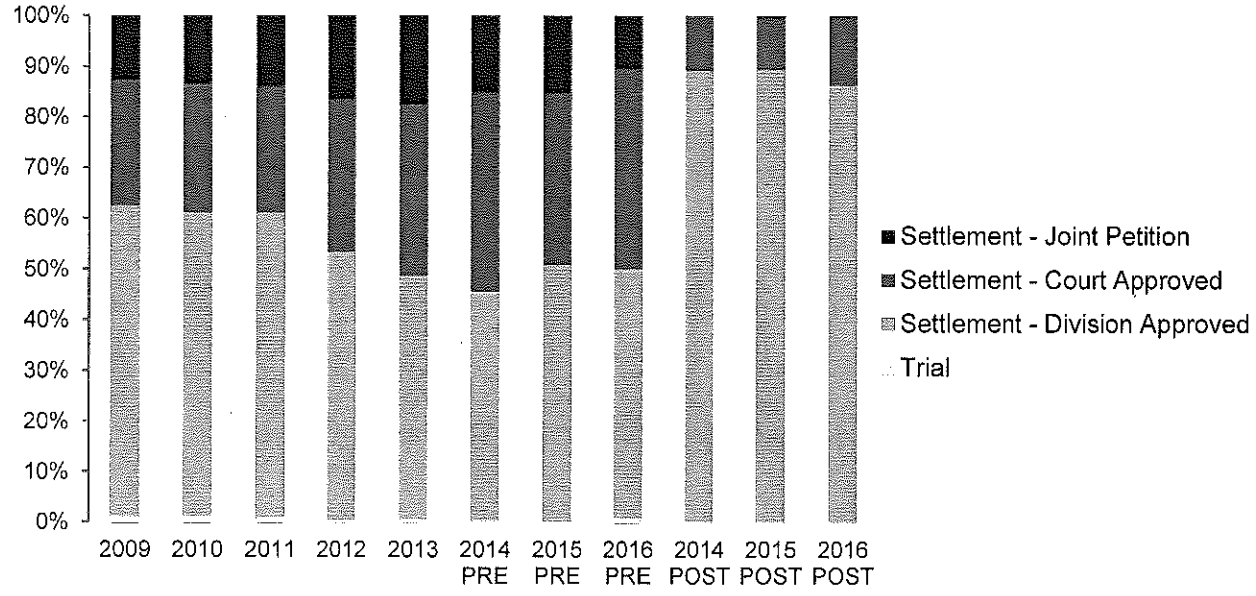
Trials were utilized in a decreasing amount, from 1.1% of conclusion types in 2009 to 0.2% in 2015 pre act cases. There were eleven (11) trails in 2016 comprising 0.7% of pre act cases. Joint petition settlement utilization decreased from 17.6% in 2013 to 10.4% in 2016 pre act cases. After decreasing from 61.4%, half (49.2%) of 2016 pre act cases were Division approved settlements. Court approved settlements continued to increase from 24.7% of settlements in 2009 to 39.7% of 2016 pre act cases. Post act conclusion types are included as well, however, SD-1 conclusion type options were designed for a court based system.

[1] Now referred to as the Bureau of Workers' Compensation

Frequency and Percent of Workers' Compensation Conclusion Types

	Trial		Settlement-Joint Petition		Settlement - Division Approved		Settlement - Court Approved		Total
Year	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency
2009	88	1.0	1135	12.9	5398	61.4	2174	24.7	8795
2010	93	1.1	1122	13.7	4908	59.9	2075	25.3	8198
2011	60	0.8	1112	14.0	4789	60.3	1984	25.0	7945
2012	42	0.5	1397	16.5	4472	52.7	2570	30.3	8481
2013	45	0.5	1580	17.6	4316	48.0	3047	33.9	8988
2014 PRE	22	0.3	1236	15.2	3675	45.2	3201	39.4	8134
2015 PRE	13	0.2	701	15.2	2345	50.1	1553	33.7	4612
2016 PRE	11	0.7	163	10.4	722	49.2	622	39.7	1568
2014 POST	-	-	-	-	41	89.1	5	10.9	46
2015 POST	-	-	12	0.4	2463	89.4	280	10.2	2755
2016 POST	1	0.0	10	0.2	5239	86.3	823	13.6	6073

Percent of Workers' **Compensation Conclusion Types**

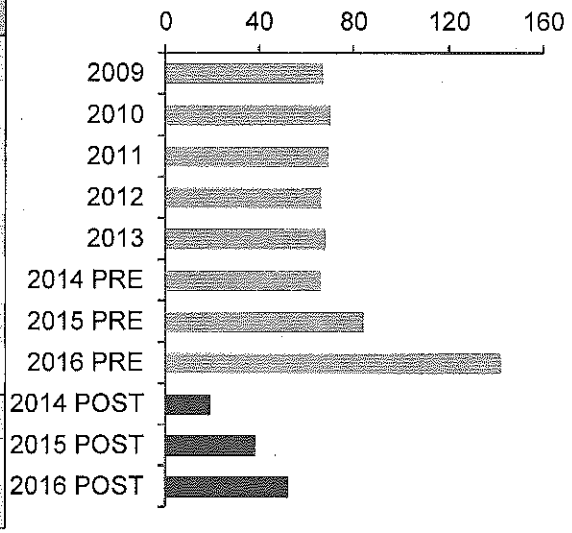


Date of Injury to Date of Conclusion

The median duration of 2016 post act cases was 52 weeks, or one year. Between 2009 and 2014 (pre act), case lengths averaged around a year and three to four months. The median case length for 2015 pre act cases from the date of injury to the date of conclusion increased to over a year and half (84.5 weeks). By 2016, pre act cases took a median of 142 weeks, or almost 2 years 9 months to conclude. The following table displays total case length averages for all conclusion types for cases involving permanent disability. If case durations are analyzed by year, not split between pre and post act cases, the median number of weeks from injury to conclusion for 2016 is 60.

Average Number of Weeks from Date of Injury to Date of Conclusion

Year	N	Median	Mean	Std. Deviation
2009	8751	67.0	84.3	60.5
2010	8166	70.0	87.6	62.3
2011	7917	69.0	85.7	59.7
2012	8457	66.0	83.7	60.7
2013	8952	68.0	86.7	65.4
2014 PRE	8109	66.0	85.4	67.0
2015 PRE	4578	84.5	113.2	86.9
2016 PRE	1533	142.0	173.4	91.3
2014 POST	46	19.0	19.2	3.3
2015 POST	2753	38.0	39.3	13.4
2016 POST	6068	52.0	54.6	22.7

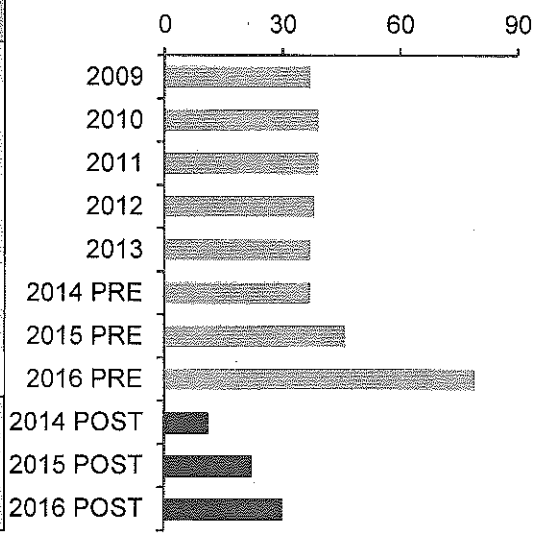


Date of Injury to Date of Maximum Medical Improvement

The following table presents the average number of weeks from the date of injury to the date of maximum medical improvement. The median duration for 2016 post act cases from the date of injury to the date of MMI was 30 weeks. Median amounts from 2009 to 2014 pre act cases ranged from 37 to 39 weeks. As a higher percentage of cases are conducted under the reform act, the length of time from injury to MMI for pre act cases increased rapidly. The median number of weeks from injury to MMI for 2016 pre act cases increased to 79. The combined median number of weeks for 2016 cases from injury to MMI was 34.

Average Number of Weeks from the Date of Injury to the Date of MMI

Year	N	Median	Mean	Std. Deviation
2009	8084	37.0	49.1	44.1
2010	7601	39.0	51.2	42.9
2011	7415	39.0	50.7	44.6
2012	8003	38.0	49.8	43.5
2013	8267	37.0	51.1	49.8
2014 PRE	7711	37.0	50.7	50.8
2015 PRE	4213	46.0	61.2	58.9
2016 PRE	1403	79.0	95.1	73.0
2014 POST	43	11.0	10.7	3.3
2015 POST	2667	22.0	23.7	11.7
2016 POST	5891	30.0	33.4	18.6

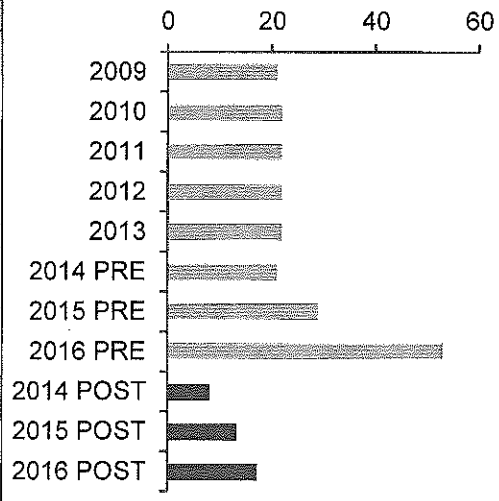


Date of MMI to Date of Conclusion

For 2016 pre act cases, the median length of time from the date of maximum medical improvement to the date of conclusion was 53 weeks, compared to 17 weeks for 2016 post act cases. The median number of weeks from MMI to conclusion was consistently 21 or 22 weeks for 2009 to 2014 pre act cases. The combined median duration from MMI to conclusion for 2016 cases was 20 weeks.

Average Number of Weeks from the Date of MMI to the Date of Conclusion

Year	N	Median	Mean	Std. Deviation
2009	8159	21.0	34.5	41.1
2010	7665	22.0	36.1	45.5
2011	7452	22.0	34.9	41.6
2012	8030	22.0	34.0	39.6
2013	8366	22.0	34.0	38.8
2014 PRE	7753	21.0	33.7	39.1
2015 PRE	4251	29.0	43.2	46.7
2016 PRE	1423	53.0	70.6	63.0
2014 POST	44	8.0	13.0	32.5
2015 POST	2679	13.0	15.9	11.9
2016 POST	5894	17.0	21.4	16.0

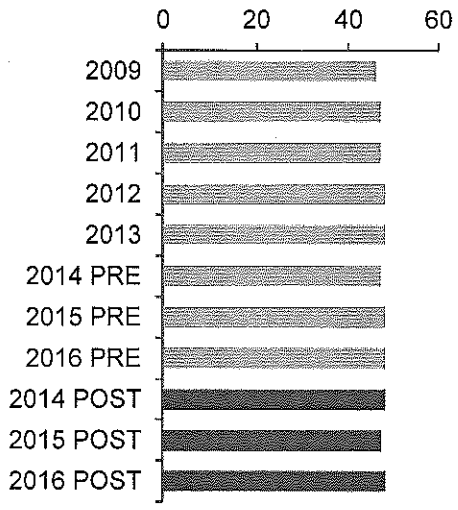


Age

Median ages of injured workers in cases that involved permanent disability ranged from 46 to 48 years. The median age for injured workers for 2016 pre and post act cases was 48. The average age of injured workers in cases involving permanent disability is one of the few consistent measures over time.

Average Age of Injured Workers

Year	N	Median	Mean	Std. Deviation
2009	5779	46.0	45.2	11.6
2010	5147	47.0	45.8	11.2
2011	5110	47.0	46.2	11.5
2012	5639	48.0	46.6	11.6
2013	6072	48.0	46.6	11.6
2014 PRE	5409	47.0	46.3	11.6
2015 PRE	2877	48.0	46.7	11.7
2016 PRE	863	48.0	47.0	11.5
2014 POST	31	48.0	47.6	12.0
2015 POST	2040	47.0	45.9	12.5
2016 POST	4319	48.0	46.6	12.3



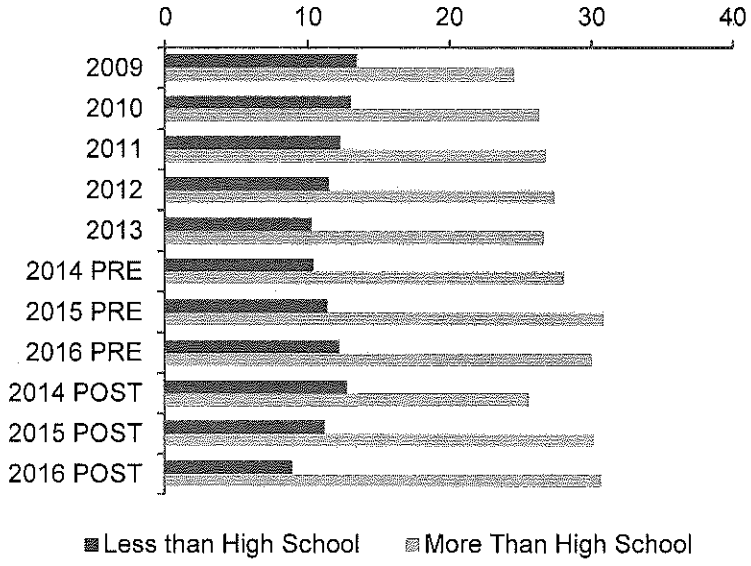
Education

For 2016 post act cases, 60.3% of injured workers had a high school education, 8.9% had less than a full high school education, and 30.7% had more than a high school education. There was an overall upward trend in education levels. When pre and post act cases were combined, 9.6% had less than a high school education, 59.8% had the equivalent of a high school education, and 30.6% had more than a high school education.

Educational Attainment of Injured Workers

		Percent		
Year	N	Less than High School	High School/GED	More Than High School
2009	6670	13.5	61.9	24.6
2010	6126	13.0	60.6	26.3
2011	5927	12.3	60.9	26.8
2012	6508	11.5	61.1	27.4
2013	6397	10.3	63.1	26.7
2014 PRE	5692	10.4	61.5	28.1
2015 PRE	3283	11.4	57.7	30.9
2016 PRE	1568	12.3	57.6	30.1
2014 POST	39	12.8	61.5	25.6
2015 POST	2104	11.2	58.6	30.2
2016 POST	6073	8.9	60.3	30.7

Percent of Injured Workers with Less Than or More Than a High School Education

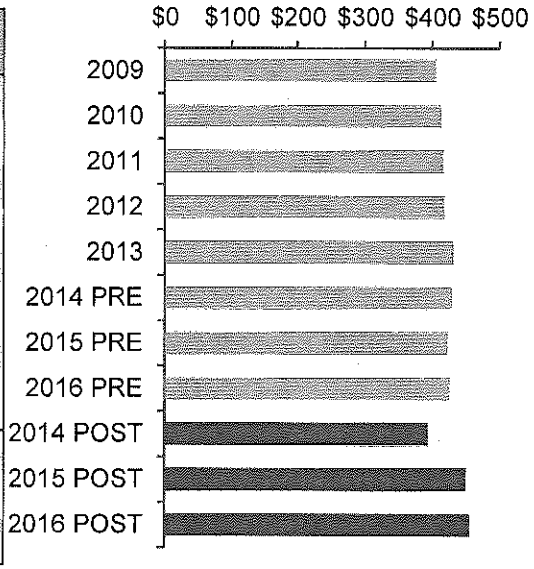


Compensation Rate

The median weekly compensation rate for 2016 post act cases increased $5 to $456. The median compensation rate for injured workers in 2016 pre act cases was $427. When pre and post act years are combined, a slight upward trend exists. The combined median compensation rate for 2016 was $451.

Average Compensation Rates for Injured Workers

Year	N	Median	Mean	Std. Deviation
2009	8529	$406	$432	$184
2010	8016	$415	$442	$189
2011	7805	$418	$446	$193
2012	8350	$419	$447	$196
2013	8874	$432	$459	$201
2014 PRE	8016	$430	$461	$209
2015 PRE	4510	$425	$462	$209
2016 PRE	1528	$427	$463	$211
2014 POST	46	$394	$418	$197
2015 POST	2697	$451	$481	$215
2016 POST	5971	$456	$487	$218

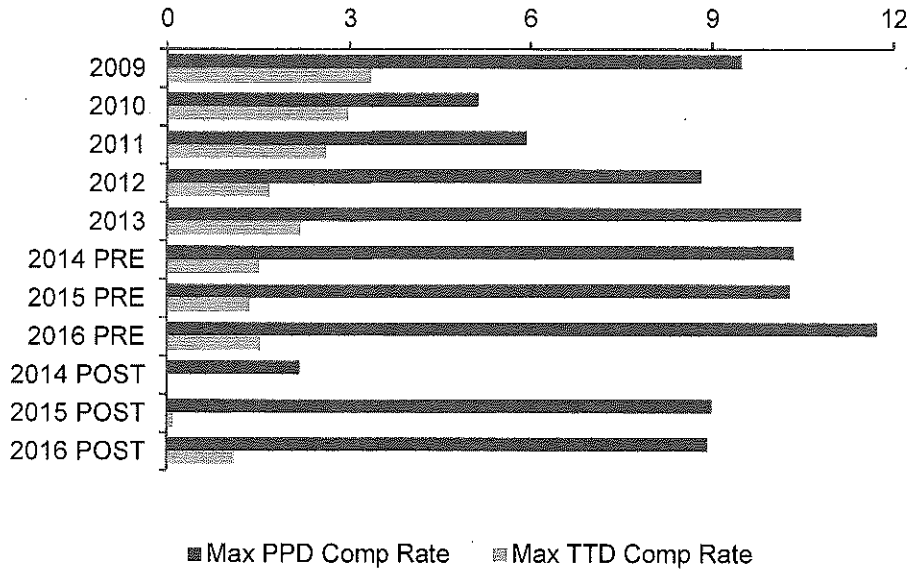


Maximum Compensation Rate

Temporary total benefits are capped at 110% of the Tennessee's average weekly wage. Permanent partial benefits are capped at 105% of the state's average weekly wage. The following charts show the percent of cases with compensation rates capped at the maximum amount for 2009 to 2016 cases. For 2016 post act cases, 8.9% were capped at the PPD maximum and 1.1% were capped at the TTD maximum.

Frequency and Percent of Cases with Maximum Compensation Rates

	Max PPD Comp Rate		Max TTD Comp Rate	
Year	N	Percent	N	Percent
2009	807	9.5	285	3.3
2010	410	5.1	238	3.0
2011	462	5.9	204	2.6
2012	736	8.8	140	1.7
2013	928	10.5	195	2.2
2014 PRE	824	10.3	121	1.5
2015 PRE	465	10.3	61	1.3
2016 PRE	184	11.7	24	1.5
2014 POST	1	2.2	0	0.0
2015 POST	244	9.0	3	0.1
2016 POST	542	8.9	67	1.1

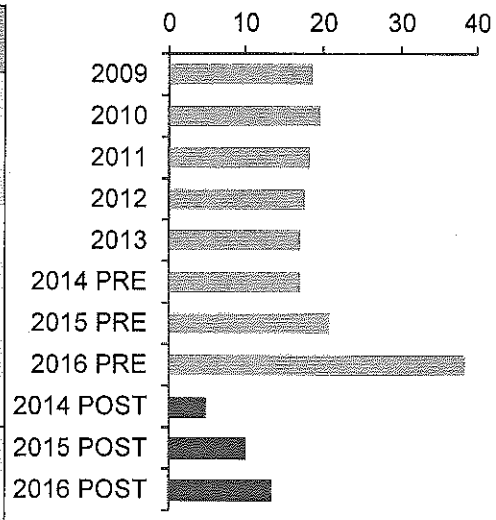


Number of Weeks of Temporary Total Disability Benefits

The median number of weeks of temporary total benefits paid for cases involving permanent injury increased to 13.4 for 2016 post act cases. The median number of weeks of TTD benefits for 2016 pre act cases nearly doubled from the previous year to 38.5 weeks. This amount reflects the increase in the number of weeks from injury to MMI. The charts below represent the average number of weeks of TTD benefits paid for all injury types and severities where there has been permanent disability. The combined median TTD number of weeks for all 2016 cases was 15.6 weeks.

Average Number of Weeks of Temporary Total Disability Benefits Paid

Year	N	Median	Mean	Std. Deviation
2009	5624	18.6	32.2	40.1
2010	5374	19.6	34.8	44.4
2011	5185	18.2	33.9	45.1
2012	5678	17.6	31.8	42.2
2013	5851	17.0	31.5	43.0
2014 PRE	5516	17.0	31.2	42.7
2015 PRE	3091	20.9	34.6	40.2
2016 PRE	1021	38.5	72.7	90.8
2014 POST	26	4.7	7.3	6.2
2015 POST	1787	10.0	13.8	15.5
2016 POST	4356	13.4	20.9	25.0

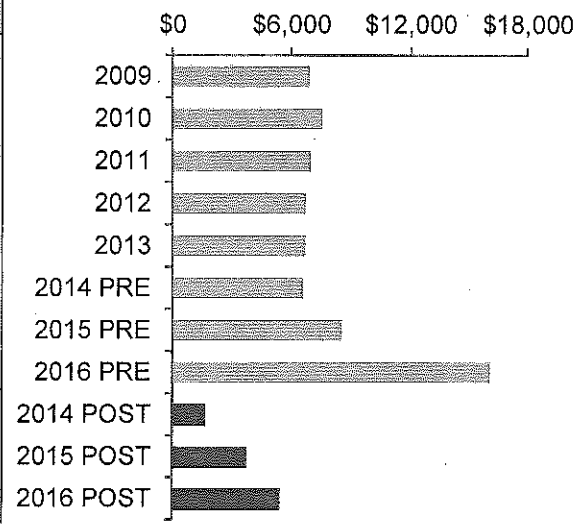


Temporary Total Disability Benefit Amounts

The median amount of TTD benefits was $5,408 for 2016 post act cases. For 2016 pre act cases, the median amount of TTD benefits paid nearly doubled to $16,095. The tables below depict the average amounts paid for TTD benefits from 2009 to 2016. The combined median TTD amount for 2016 was $6,315.

Average Amounts of Temporary Total Disability Benefits Paid

Year	N	Median	Mean	Std. Deviation
2009	5624	$6,872	$12,803	$16,232
2010	5374	$7,530	$13,928	$16,947
2011	5185	$6,932	$13,470	$17,367
2012	5678	$6,696	$12,875	$16,560
2013	5851	$6,692	$12,631	$16,266
2014 PRE	5516	$6,592	$12,429	$15,888
2015 PRE	3091	$8,540	$14,685	$17,475
2016 PRE	1021	$16,095	$32,683	$47,476
2014 POST	26	$1,650	$2,595	$2,285
2015 POST	1787	$3,746	$5,996	$6,851
2016 POST	4356	$5,408	$9,605	$13,615

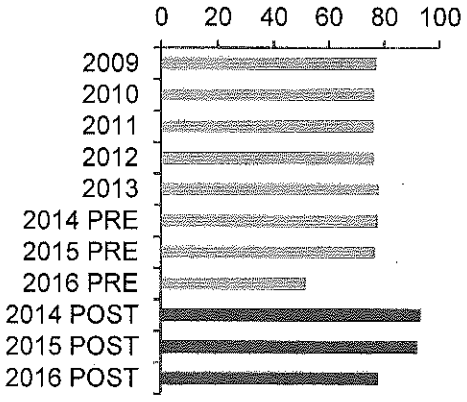


Return to Work

The SD-1 form has a field to indicate whether the employee returned to work for the same employer. This is the field used to delineate return to work status for permanent partial impairment and permanent partial disability reporting. The following charts depict the percent of SD-1 forms per year that indicated the employee returned to work for their pre injury employer. In 77.8% of 2016 post act cases the injured workers returned to work, compared to 51.9% of 2016 pre act cases.

Percent of Injured Workers That Returned to Pre Injury Employment

Year	N	Percent
2009	6422	77.3
2010	5916	76.4
2011	5773	76.3
2012	6350	76.3
2013	6904	78.2
2014 PRE	6212	77.9
2015 PRE	3350	76.9
2016 PRE	741	51.9
2014 POST	43	93.5
2015 POST	2425	92.1
2016 POST	4489	77.8



Permanent Partial Impairment Ratings – Employee Returned to Work

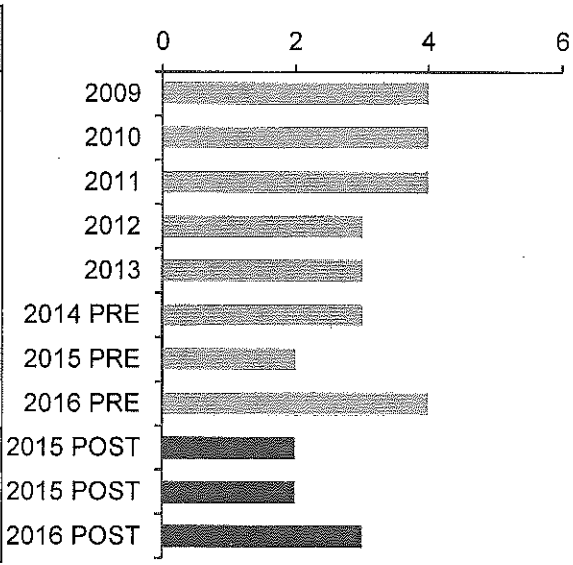
Cases were selected with only one permanent disability per side to be able to get as accurate of a picture as possible for permanent impairment, disability, and subsequent multipliers. This included those with no side indicated. For example, an injury to the left shoulder would result in a left PPI rating and PPD amount. If that same case also had an injury to the left arm, it would not be possible to piece back together which PPI rating went with which PPD amount. Analyzing single side injury information allowed for clean determination of which impairment ratings went with the corresponding disability and accounted for over 98% of permanent impairment cases. Multiple injuries were included if the injuries were to different, or no, sides. Less than 1% of 2016 cases had injury information to more than one side.

For all cases with dates of injury before the implementation of the reform act, scheduled member impairment ratings have been converted to body as a whole equivalents. This was done using the AMA guides. The average PPI ratings reported below are for all injury types, scheduled member ratings converted to body as a whole and as body as a whole ratings together. Previous reports showed a decreasing trend in PPI ratings. The median PPI rating

for 2016 post act return to work cases was 3.0. The median PPI rating for pre act cases was 4.0.

Average PPI Ratings – Employee Returned to Work

Year	N	Median	Mean	Std. Deviation
2009	5190	4.0	6.0	6.6
2010	4882	4.0	5.7	6.7
2011	4822	4.0	5.4	6.1
2012	5163	3.0	4.9	5.5
2013	5482	3.0	4.9	5.9
2014 PRE	5074	3.0	4.7	5.5
2015 PRE	1270	2.0	3.5	4.5
2016 PRE	741	4.0	5.8	5.8
2015 POST	31	2.0	2.2	1.4
2015 POST	200	2.0	3.3	2.9
2016 POST	4484	3.0	3.6	3.7



Percentage Awarded for Permanent Partial Disability – Employee Returned to Work

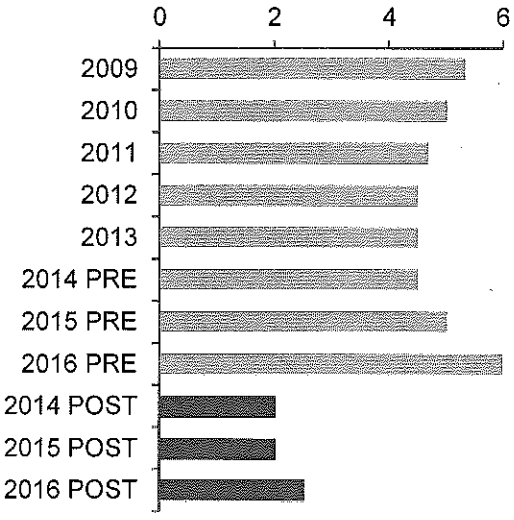
Like the PPI ratings, scheduled member PPD amounts have been converted to body as a whole and are reported together in the following charts. Pre act scheduled member disability amounts were converted using the following formula:

$$\text{Case PPD Amount} \times \frac{\text{Scheduled Member \# of weeks}}{\text{400 (previous BAW \# of weeks)}}$$

The median PPD amount for 2016 post act return to work cases was 2.5. The median PPD percent amount for 2012 to 2014 pre act cases was 4.5, then increased to 6.0 for 2016 pre act cases.

Average PPD Percent – Employee Returned to Work

Year	N	Median	Mean	Std. Deviation
2009	4281	5.3	8.4	9.8
2010	4177	5.0	8.2	10.0
2011	4294	4.7	7.7	9.6
2012	4637	4.5	6.9	8.3
2013	5052	4.5	6.7	8.3
2014 PRE	3911	4.5	6.7	8.7
2015 PRE	1821	5.0	7.5	8.9
2016 PRE	741	6.0	9.6	10.9
2014 POST	21	2.0	2.8	2.8
2015 POST	1258	2.0	3.4	4.5
2016 POST	4484	2.5	3.7	4.2

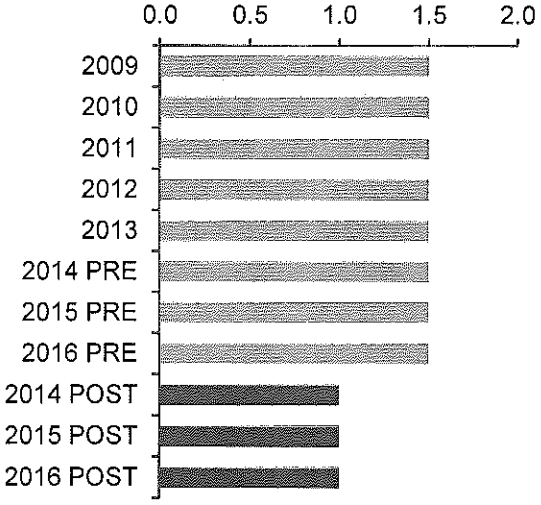


Permanent Partial Disability Multipliers – Employee Returned to Work

A permanent partial disability multiplier is the ratio of the PPD judgment or settlement amount to the highest PPI rating associated with an injury. PPD multipliers are calculated by dividing the PPD percent amount by the highest PPI rating. PPD multipliers reported in the tables below present the combination of converted scheduled member injuries with body as a whole injuries. The PPD multiplier for all post act cases was 1.0, the statutory multiplier for cases where the injured workers were returned to pre injury employment. The median PPD multipliers for all pre act cases was 1.5.

Average PPD Multipliers – Employee Returned to Work

Year	N	Median	Mean	Std. Deviation
2009	4139	1.5	1.6	1.3
2010	4084	1.5	1.6	1.2
2011	4190	1.5	1.5	0.9
2012	4542	1.5	1.6	1.1
2013	4925	1.5	1.6	1.3
2014 PRE	3810	1.5	1.5	1.3
2015 PRE	858	1.5	1.7	1.7
2016 PRE	665	1.5	1.6	1.2
2014 POST	19	1.0	1.0	0.4
2015 POST	98	1.0	1.0	0.3
2016 POST	4397	1.0	1.1	1.5

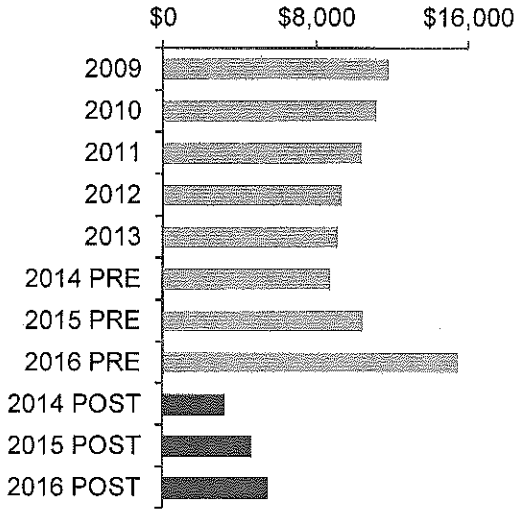


Permanent Partial Disability – Monetary Benefits – Employee Returned to Work

The median amount for 2016 post act return to work cases was $5,444. Median PPD monetary benefits reduced from $11,809 in 2009 to $8,707 for 2014 pre act cases then began to increase. For 2016 pre act cases, the median PPD amount increased to $15,499. Average amounts reported in the table below consist of the combination of converted scheduled member injuries with body as a whole injuries.

Average PPD Benefit Amount – Employee Returned to Work

Year	N	Median	Mean	Std. Deviation
2009	5185	$11,809	$25,558	$47,367
2010	4852	$11,145	$25,203	$50,940
2011	4854	$10,366	$23,844	$48,826
2012	5181	$9,302	$20,855	$43,829
2013	5542	$9,133	$19,741	$37,402
2014 PRE	5162	$8,707	$19,318	$42,400
2015 PRE	2700	$10,438	$22,862	$44,353
2016 PRE	708	$15,499	$34,924	$54,515
2014 POST	34	$3,181	$4,464	$3,805
2015 POST	2198	$4,579	$7,844	$12,387
2016 POST	4367	$5,444	$9,460	$13,768

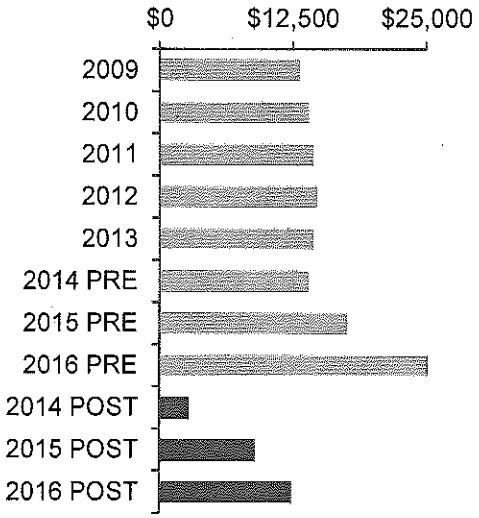


Medical Benefits/Expenses – Employee Returned to Work

Average medical benefits/expenses for cases where the injured workers were returned to pre injury employment are reported in the charts below. Average medical amounts reported are for combined scheduled member and body as a whole cases. The median amount for 2016 post act cases was $12,384. Pre act cases ranged from a median of $13,135 in 2009 to $25,646 in 2016.

Average Medical Benefit/Expense – Employee Returned to Work

Year	N	Median	Mean	Std. Deviation
2009	4953	$13,135	$22,264	$37,946
2010	4646	$13,967	$24,905	$44,866
2011	4668	$14,401	$25,671	$48,283
2012	5070	$14,745	$24,622	$42,800
2013	5453	$14,378	$25,127	$55,397
2014 PRE	5070	$13,926	$25,315	$63,591
2015 PRE	2612	$17,636	$29,613	$54,515
2016 PRE	701	$25,646	$48,808	$78,643
2014 POST	35	$2,698	$3,987	$3,657
2015 POST	2182	$8,936	$12,827	$14,799
2016 POST	4411	$12,384	$18,134	$31,430

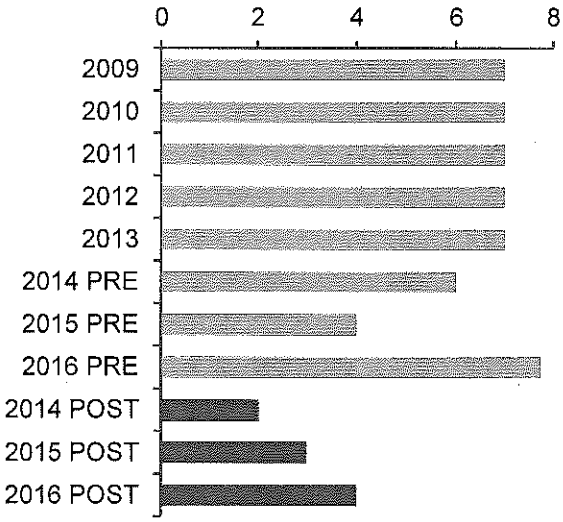


Permanent Partial Impairment Ratings – Employee did not Return to Work

Using the same methods as cases where the injured worker was returned to pre injury employment, cases involving single side injuries were selected for PPI, PPD, multiplier, and medical amount for analysis of non return to work experiences. Additionally, scheduled member PPI ratings were converted to body as a whole using the AMA guides. The median PPI rating for 2016 post act cases was 4.0. The median PPD rating for 2016 pre act non return to work cases was 7.8.

Average PPI Ratings – Employee did not Return to Work

Year	N	Median	Mean	Std. Deviation
2009	2459	7.0	10.7	10.8
2010	2414	7.0	10.6	11.5
2011	2280	7.0	9.6	9.9
2012	2598	7.0	10.5	11.9
2013	2603	7.0	10.3	12.4
2014 PRE	2232	6.0	8.5	9.4
2015 PRE	469	4.0	6.8	10.4
2016 PRE	688	7.8	11.0	12.9
2014 POST	9	2.0	2.7	3.5
2015 POST	22	3.0	4.6	4.2
2016 POST	1283	4.0	5.4	6.4

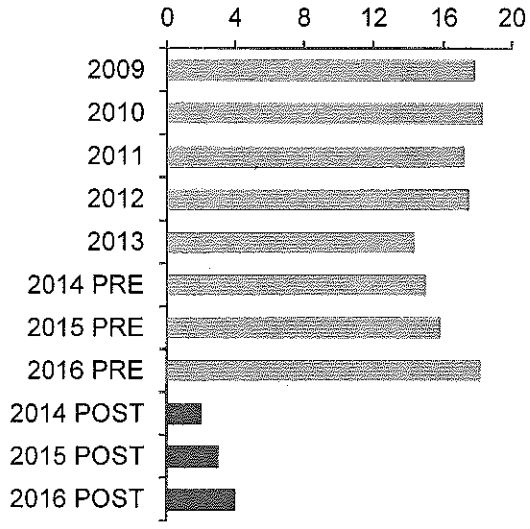


Percentage Awarded for Permanent Partial Disability – Employee did not Return to Work

The median PPD percent for 2016 pre act cases where injured workers did not return to work was 4.0. The charts below display average PPD percentages and present converted scheduled member and body as a whole amounts together. The median PPD percent for pre act cases was 18.2.

Average PPD Percent - Employee did not Return to Work

Year	N	Median	Mean	Std. Deviation
2009	2078	17.8	24.7	22.2
2010	2096	18.3	25.4	22.3
2011	1965	17.2	23.7	21.0
2012	2301	17.5	23.6	21.1
2013	2465	14.4	21.7	21.0
2014 PRE	1690	15.0	21.8	21.0
2015 PRE	1082	15.8	21.9	20.8
2016 PRE	688	18.2	25.6	30.9
2014 POST	5	2.0	5.9	6.4
2015 POST	209	3.0	4.9	5.1
2016 POST	1283	4.0	6.1	8.3

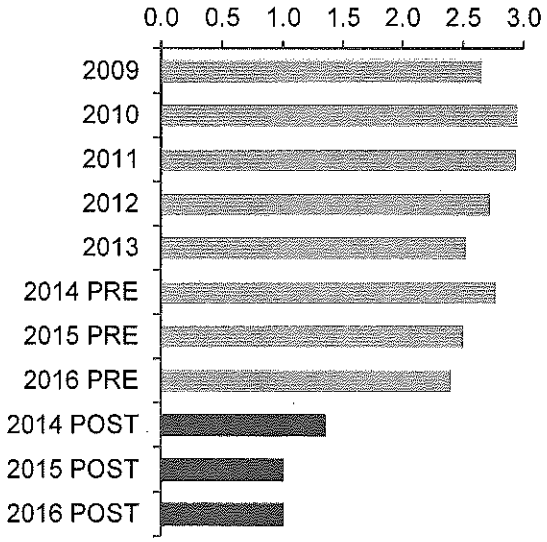


Permanent Partial Disability Multipliers – Employee did not Return to Work

The PPD multiplier for 2016 post act cases where the injured worker did not return to work was 1.0. Pre act permanent partial disability multipliers for cases involving permanent injury where injured workers did not return to pre injury employment ranged from 2.4 to 2.9. This does not include cases that were reconsidered due to changes related to the injured workers' work status or other factors of reconsideration.

Average PPD Multiplier - Employee did not Return to Work

Year	N	Median	Mean	Std. Deviation
2009	1985	2.7	2.8	1.8
2010	2038	2.9	3.1	2.6
2011	1906	2.9	3.0	2.2
2012	2238	2.7	3.0	2.4
2013	2298	2.5	3.2	6.4
2014 PRE	1641	2.8	3.1	4.7
2015 PRE	318	2.5	4.0	7.6
2016 PRE	608	2.4	3.0	4.6
2014 POST	5	1.4	1.7	1.3
2015 POST	9	1.0	1.1	0.7
2016 POST	1242	1.0	1.2	0.9

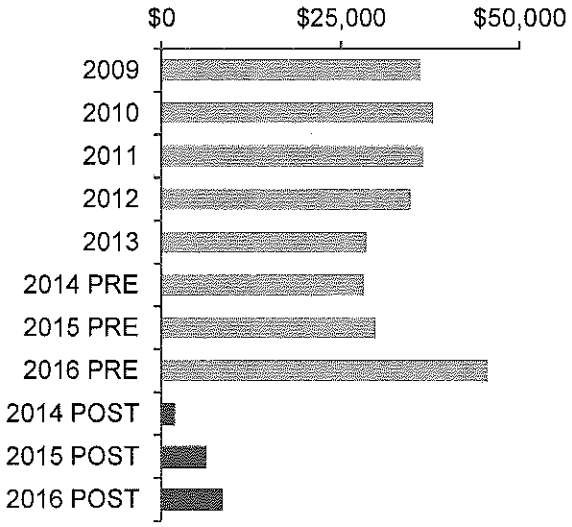


Permanent Partial Disability – Monetary Benefits – Employee did not Return to Work

The following charts display average medical expenses paid for cases involving permanent disability where injured workers did not return to work. The median PPD amount paid for injured workers who did not return to pre injury employment for 2016 post act cases was $8,400. The median amount paid for 2016 pre act non return to work PPD benefits was $45,800.

Average PPD Benefit Amounts - Employee did not Return to Work

Year	N	Median	Mean	Std. Deviation
2009	2477	$36,363	$69,186	$96,081
2010	2434	$38,125	$76,013	$123,561
2011	2300	$36,654	$73,954	$120,956
2012	2619	$35,030	$71,796	$115,366
2013	2741	$28,767	$67,720	$115,956
2014 PRE	2245	$28,333	$65,833	$117,224
2015 PRE	1596	$29,968	$68,933	$116,767
2016 PRE	635	$45,800	$94,236	$145,613
2014 POST	9	$1,850	$5,004	$6,748
2015 POST	364	$6,190	$12,565	$25,605
2016 POST	1239	$8,400	$18,305	$32,176

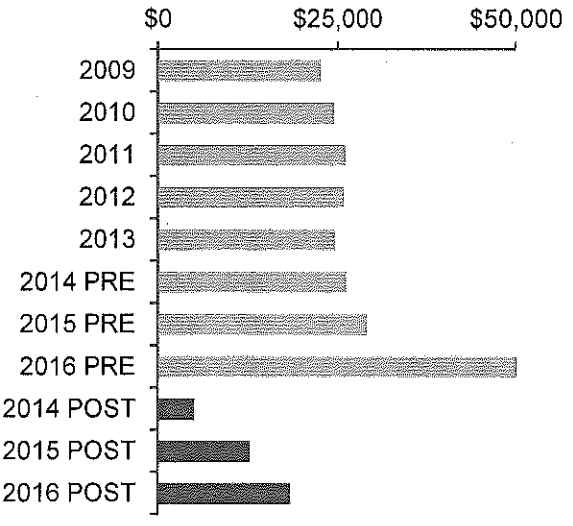


Medical Benefits/Expenses – Employee did not Return to Work

The median amount paid for 2016 post act cases was $18,301. Average medical benefits/expenses for cases where the injured workers were not returned to pre injury employment are displayed below. The median amount paid for 2016 pre act cases was $50,972.

Average Medical Benefits/Expenses - Employee did not Return to Work

Year	N	Median	Mean	Std. Deviation
2009	2177	$22,473	$55,529	$425,890
2010	2150	$24,440	$52,777	$112,086
2011	2056	$26,077	$56,797	$138,057
2012	2310	$25,850	$62,734	$230,356
2013	2324	$24,503	$69,653	$576,212
2014 PRE	2081	$26,159	$56,645	$132,151
2015 PRE	1325	$29,158	$67,987	$158,015
2016 PRE	551	$50,972	$106,777	$197,979
2014 POST	10	$4,935	$6,924	$6,253
2015 POST	375	$12,682	$21,270	$38,729
2016 POST	1244	$18,301	$31,763	$60,244

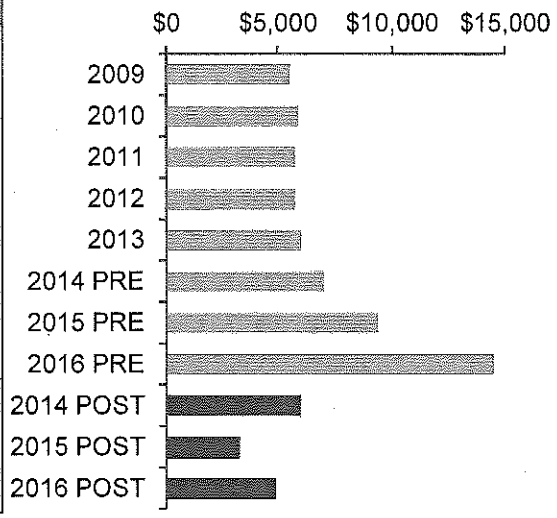


Lump Sum Benefits

For 2016 post act cases, the median lump sum amount paid was $4,879. The following charts depict the average lump sum amounts paid at the time of conclusion. The median lump sum amount increased to $14,500 in 2016 pre act cases. The numbers reported represent all cases, regardless of return to work status.

Average Lump Sum Benefits Paid

Year	N	Median	Mean	Std. Deviation
2009	261	$5,536	$19,289	$51,568
2010	252	$5,900	$20,967	$51,707
2011	270	$5,738	$17,801	$43,816
2012	460	$5,738	$18,353	$72,835
2013	396	$6,000	$18,432	$70,114
2014 PRE	257	$7,000	$23,270	$82,739
2015 PRE	184	$9,354	$42,688	$163,549
2016 PRE	103	$14,500	$40,162	$78,919
2014 POST	2	$6,000	$6,000	$0
2015 POST	74	$3,284	$8,112	$12,684
2016 POST	171	$4,879	$8,605	$13,727

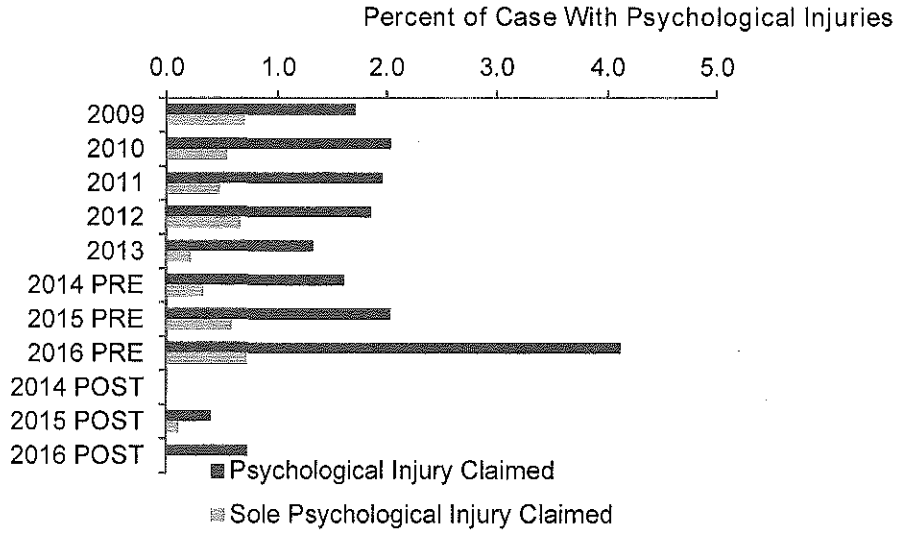


Psychological Injury

Psychological injury can be associated with workers' compensation cases in two ways, an injured worker can claim psychological injury in addition to other injuries, or it can be the sole injury. The chart below displays the frequency and percent of claims involving psychological injury. For 2016 post act cases, 43 (0.7%) claimed psychological injury and in 14 cases (0.2%), psychological injury was the sole claim. For 2016 pre act cases, 63 (4.1%) involved psychological injury and in 11 (0.7%) cases, psychological injury was the sole claim.

Frequency of Psychological Injuries

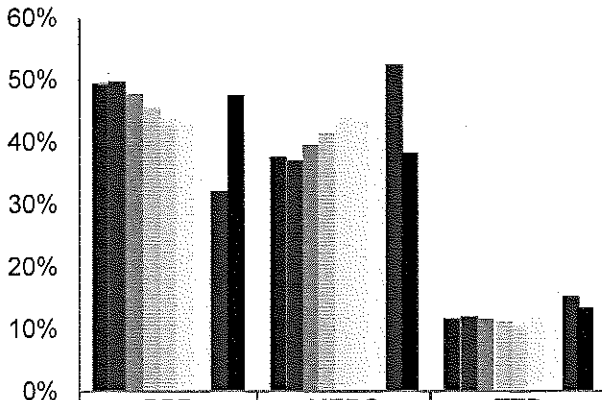
	Psychological Injury Claimed		Sole Psychological Injury Claimed	
Year	N	Percent	N	Percent
2009	151	1.7	62	0.7
2010	167	2.0	45	0.5
2011	156	2.0	38	0.5
2012	158	1.9	56	0.7
2013	119	1.3	20	0.2
2014 PRE	131	1.6	27	0.3
2015 PRE	94	2.0	27	0.6
2016 PRE	63	4.1	11	0.7
2014 POST	0	0.0	0	0.0
2015 POST	11	0.4	3	0.1
2016 POST	43	0.7	14	0.2



Medical & Indemnity Summary

The following chart displays the percent of all medical and indemnity dollars paid at the time of conclusion as indicated on SD-1 forms. This does not include payments made in medical only claims. With 2016 still bifurcated between pre and post act case types, systemic trend implications should be avoided for 2014 through 2016 cases. While some benefit amounts were paid for lump sum, permanent total disability and death benefits, the percentages were less than a half of a percent for many of the years. 2014 post act cases were not included due to the low number of cases.

Percent Paid for All Medical and Indemnity Dollars at Conclusion



	PPD	MEDS	TTD	LUMP	PTD	DEATH
2009	49%	38%	12%	1%	0%	0%
2010	50%	37%	12%	1%	0%	0%
2011	48%	40%	12%	1%	0%	0%
2012	46%	42%	11%	1%	0%	0%
2013	44%	44%	11%	1%	0%	0%
2014 PRE	43%	43%	12%	1%	0%	0%
2015 PRE	42%	40%	16%	2%	0%	0%
2015 POST	32%	53%	15%	0%	0%	0%
2016 POST	48%	38%	13%	0%	0%	0%

Conclusion

As also observed in 2015 cases, 2016 pre act cases typically are taking longer and have higher temporary total disability, permanent partial disability, medical, and lump sum costs. This is to be expected and serves to provide validity to the data that was available. When 2016 data is combined, rather than looking at pre and post act cases separately, median amounts look typical to pre reform act years. 2016 is still a transition year between pre and post act cases, with higher cost and duration cases occurring under the pre act system, while also being precluded from the post act data. 2017 data should present information that is largely post act in nature.

RULES
OF
TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
WORKERS' COMPENSATION DIVISION

CHAPTER 0800-02-25
WORKERS' COMPENSATION MEDICAL TREATMENT GUIDELINES

TABLE OF CONTENTS

0800-02-25.01 PURPOSE AND SCOPE.

(1) Purpose: To provide guidelines for the diagnosis and treatment of commonly occurring workers' compensation injuries.

(2) Scope: To include guidelines for diagnostic and treatment requests including pharmaceuticals and pain management.

Authority: *T.C.A. § 50-6-124.* ***Administrative History:*** *Original rule filed November 30, 2015; effective February 28, 2016.*

0800-02-25-.02 DEFINITIONS.

(1) "Act" means the applicable Workers' Compensation Law in effect.

(2) "Administrator" means the chief administrative officer of the Tennessee Bureau of Workers' Compensation, or the Administrator's designee.

(3) "Authorized Treating Physician" means the practitioner chosen from the panel required by T.C.A. § 50-6-204, or a practitioner who has received a referral from the original authorized treating physician if the employer has not provided an alternative referral within three business days. "Authorized Treating Physician" also means any practitioner specifically authorized by the employer.

(4) "Bureau" means the Tennessee Bureau of Workers' Compensation attached for administrative purposes to the Tennessee Department of Labor and Workforce Development.

(5) "Employee" means an employee as defined in T.C.A. § 50-6-102, but also includes the employee's representative or legal counsel.

(6) "Employer" means an employer as defined in T.C.A. § 50-6-102, but also includes an employer's insurer, third party administrator, self-insured employers, self-insured pools and trusts, as well as the employer's representative or legal counsel, as applicable.

(7) "Health care provider" includes, but is not limited to, the following: licensed individual chiropractic physician, dentist, physical therapist, physician, physician assistant, optometric physician, podiatrist, surgeon, occupational therapist, group of practitioners, hospital, free standing surgical outpatient facility, health maintenance organization, industrial or other clinic, occupational healthcare center, home health agency, visiting nursing association, laboratory, medical supply company, community mental health center, pharmacist/pharmacy, and any other facility or entity providing treatment or health care services for a work-related injury.

(Rule 0800-02-25-.02, continued)

(8) "Medical Director" means the Medical Director of the Tennessee Bureau of Workers' Compensation appointed by the Administrator pursuant to T.C.A. § 50-6-126, or the Medical Director's designee.

(9) "Medically necessary" or "medical necessity" means healthcare services, including medications, that a physician (or other healthcare provider acting within their scope of practice), exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

(a) In accordance with generally accepted standards of medical practice; and

(b) Clinically appropriate, in terms of type, frequency, extent, site and duration; and considered effective for the patient's illness, injury or disease. Treatment primarily for the convenience of the patient, physician, or other healthcare provider does not constitute medical necessity.

(10) "Treatment guideline" means the Institute of Medicine (2011) definition of a "clinical practice guideline": "statements that include recommendations intended to optimize patient care that are informed by a systematic review of the evidence and an assessment of the benefit and harms of alternative care options."

(11) "Utilization review" means evaluation of the necessity, appropriateness, efficiency and quality of medical care services, including the prescribing of one (1) or more Schedule II, III, or IV controlled substances for pain management for a period of time exceeding ninety (90) days from the initial prescription of such controlled substances, provided to an injured or disabled employee based on medically accepted standards and an objective evaluation of those services provided; provided, that "utilization review" does not include the establishment of approved payment levels, a review of medical charges or fees, or an initial evaluation of an injured or disabled employee by a physician specializing in pain management;

(a) "Utilization review" does not include elective requests for clarification of coverage, referrals, consultations, second opinions from medical providers, or office visits.

(b) "Utilization review" does not include analysis of or opinions regarding medical causation or compensability.

Authority: *T.C.A. §§ 50-6-102, 50-6-122, 50-6-124, 50-6-126, 50-6-233, 56-6-703, and 56-61-102.* ***Administrative History:*** *Original rule filed November 30, 2015; effective February 28, 2016.*

0800-02-25-.03 TREATMENT GUIDELINES.

(1) Effective January 1, 2016, the Tennessee Bureau of Workers' Compensation adopts the current edition, and any future published updates, of the Work Loss Data Institute ODG Guidelines as published by the Work Loss Data Institute, the Chronic Pain Guidelines of the State of Tennessee, Department of Health, and any other related appendices to the above-referenced guidelines adopted by the Administrator.

(2) Medical treatment provided by or at the direction of the authorized treating physician, or other healthcare provider, in accordance with the ODG Guidelines, Chronic Pain Guidelines of the State of Tennessee, Department of Health, and any other related appendices to the Guidelines adopted by the Administrator in effect at the date the treatment is recommended, listed in section (1) above is presumed to be reasonable and necessary. Any utilization review of treatment must apply the ODG Guidelines listed in section (1) above, in determining whether treatment is medically necessary. Any treatment that explicitly follows the treatment

(Rule 0800-02-25-.03, continued)

guidelines adopted by the administrator or is reasonably derived therefrom, including allowances for specific adjustments to treatment, shall have a presumption of medical necessity for utilization review purposes. This presumption shall be rebuttable only by clear and convincing evidence that the treatment erroneously applies the guidelines or that the treatment presents an unwarranted risk to the injured worker.

(3) It is recognized that each individual clinical situation and patient is unique. The guidelines are not a standard or a mandate. Exceptions to and the proper application of the guidelines require judgment. The Utilization Review and prior approval/authorization procedures and timeframes remain in effect. See Utilization Review Rule 0800-02-06. A mechanism for the timely appeal for these exceptional situations is set forth in Rule 0800-02-06-.07 Appeals.

(4) The employer shall not deny treatment based solely on the determination that the treatment falls outside of the guideline if such denial is not supported by documented evidence-based medicine.

(a) If a provider makes a written request by fax or e-mail (and receives acknowledgement of receipt of the request) for authorization for a treatment at least 21 business days in advance of the anticipated date that treatment is to be delivered and has not been notified in writing or confirmed telephone call or confirmed fax at least 7 business days in advance of the date of the proposed treatment, it is presumed to be medically necessary, a covered service, and to be paid for by the employer.

(b) If a provider makes a verbal request for authorization, the burden of proof for showing that authorization was granted by the employer rests with the provider.

(5) The employer shall not be responsible for charges for medical treatment that is not in accord with the guidelines unless:

(a) it was provided in a medical emergency,

(b) it was authorized by the employer,

(c) it was approved through the appeal process by the Bureau.

(6) As new information becomes available, the Administrator may direct the Medical Director to publish or post on the Division's website, advisory or explanatory updates or bulletins to the guidelines. Print copies will be made available by request to the Medical Director. The Medical Advisory Committee may be consulted at the Administrator's discretion.

(7) As of January 1, 2016, physicians and other providers dispensing drugs required to be reported in the Tennessee Controlled Substances Monitoring Database (CSMD) from their offices or clinics must report these medications in the Tennessee Controlled Substances Monitoring Database (CSMD) within one business day of the dispensing of those medications. These provisions are in accord with T.C.A. § 53-10-305, T.C.A. § 53-10-307 and T.C.A. § 53-10-310 as amended.

Authority: *T.C.A. §§ 50-6-122, 50-6-124, 50-6-126, and 50-6-233.* ***Administrative History:*** *Original rule filed November 30, 2015; effective February 28, 2016.*

0800-02-25-.04 DRUG FORMULARY.

(1) The purpose of the drug formulary is to facilitate the safe and appropriate use of medications for injured workers, and is a specific part of the Treatment Guidelines set forth in subsection .03 of this rule.

(Rule 0800-02-25-.04, continued)

(2) The Bureau adopts the ODG Drug Formulary as found in Drug Appendix A published and updated by the Work Loss Data Institute.

(3) Prescriptions presented to a pharmacy from an authorized provider and appropriate for the prescribed injury within seven (7) days of an alleged or accepted workers' compensation claim may be filled for a maximum of seven (7) days, even if the prescribed medication is status "N." The employer is responsible for the payment.

(4) The Formulary shall be made available by posting on the Bureau's website. Subsequent updates shall be effective on the first day of the month following posting of an update on the Bureau's website.

(5) Drugs identified with the status "N" in the current edition of the ODG/Appendix A, and any other related appendices adopted by the Administrator in effect at the date the treatment is recommended, shall require prior approval. An "N" drug should not be approved unless its use in a particular case is supported by documentation of evidence-based medicine.

(6) Compounded medications and topical applications are "N" and subject to prior approval. An "N" drug should not be approved unless its use in a particular case is supported by documentation of evidence-based medicine.

(7) Prescriptions for "Y" drugs should be filled without delay if they are approved as appropriate for the nature of the injury being treated.

(8) For compensation claims with a date of injury (DOI) on or after January 1, 2016, and for new medication prescriptions for dates of injury prior to January 1, 2016, the formulary applies to all drugs that are prescribed or dispensed for outpatient use on or after six-months following the effective date of these rules.

(9) For refill prescriptions and medications being used for dates of injury (DOI) before January 1, 2016, the formulary applies to all drugs that are prescribed or dispensed for outpatient care one year from the effective date of these rules.

(10) Retrospective review of medications will be allowed only for drugs that are not appropriate for the injured worker's diagnosis. Only the next refill prescribed by the authorized treating physician can be denied.

(11) The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

(a) "Closed Formulary" means all available Food and Drug Administration (FDA) approved prescription and nonprescription drugs prescribed and dispensed for outpatient use, and applies to the categories listed below that require prior approval:

1. drugs identified with a status of "N" in the current edition of the Official Disability Guidelines Treatment in Workers' Compensation (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;

2. any compound or topical; and

3. any investigational or experimental drug that has not yet been identified as a "Y" or "N" drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet accepted as the prevailing standard of care.

(b) "Compounding", "compound" or "compounded" medication or preparation means the preparation, mixing, assembling, packaging, or labeling of a drug or device:

1. as the result of a practitioner's prescription drug order based on the practitioner-patient-pharmacist relationship in the course of professional practice;

2. for administration to a patient by a practitioner as the result of a practitioner's initiative based on the practitioner-patient-pharmacist relationship in the course of professional practice;

3. in anticipation of a prescription drug order based on a routine, regularly observed prescribing pattern; or

4. for or as an incident to research, teaching, or chemical analysis and not for selling or dispensing.

(c) "Evidence-based ", medicine" (EBM) means an approach to medical practice intended to optimize decision-making by emphasizing the use of evidence from well-designed and well- conducted research, to include the integration with clinical expertise and patient values and an evolutionary progression of knowledge based on the basic and clinical sciences.

(d) "Initial Prescription" means the beginning, starting, commencing or first written order for a medication. Changes in dosage, addition of or removal of previously prescribed medications either individually or in combination are not considered an initial prescription.

(e) "Medical emergency" means the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain that in the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the patient's health or bodily functions in serious jeopardy; or

2. Serious dysfunction of any body organ or part.

(f) "Nonprescription drug" or "over-the-counter medication" means a non-narcotic drug that may be sold without a prescription and that is labeled and packaged in compliance with state or federal law.

(g) "Open Formulary" means all available Food and Drug Administration (FDA) approved prescription and nonprescription drugs prescribed and dispensed for outpatient use, but does not include drugs that lack FDA approval, or non-drug items.

(h) "Prescribing Doctor" means a physician or dentist who prescribes prescription drugs or over the counter medications in accordance with the physician's or dentist's license and state and federal laws and rules. For purposes of this chapter, prescribing doctor includes an advanced practice nurse or physician assistant to whom a physician has delegated the authority to carry out or sign prescription drug orders, who prescribes prescription drugs or over the counter medication under the physician's supervision and in accordance with the health care practitioner's license and state and federal laws and rules.

(Rule 0800-02-25-.04, continued)

(i) "Prescription" means an order for a prescription or nonprescription drug to be dispensed, in accordance with the applicable federal definition and in T.C.A. Title 53 Chapter 10.

(j) "Prescription drug" means:

1. A substance for which federal or state law requires a prescription before the substance may be legally dispensed to the public;

2. A drug that under federal law is required, before being dispensed or delivered, to be labeled with the statement: "Caution: federal law prohibits dispensing without prescription;" "Rx only;" or another legend that complies with federal law; or

3. A drug that is required by federal or state statute or regulation to be dispensed on prescription or that is restricted to use by a prescribing doctor only.

(k) "Substitution" means the dispensing of a drug or a brand of drug other than the drug or brand of drug ordered or prescribed.

(l) "Topical" means a prescription substance or substances, not injected or ingested, that are used on the skin or other membranes, or are applied to exterior or exposed surfaces. This category includes "inhalers."

(12) The provider may appeal to the Bureau's Medical Director for an expedited decision, using a request for an expedited determination.

(a) The purpose of this section is to provide a prescribing doctor or pharmacy the ability to obtain an expedited determination from the Bureau's Medical Director in instances where a denial of a previously prescribed and dispensed drug(s) for the workers' compensation injury poses an unreasonable risk of a medical emergency as defined in this title.

(b) The request for an expedited determination from the Medical Director may be rejected at the sole discretion of the Medical Director if it does not contain the following information:

1. Injured employee name;

2. Date of birth of injured employee;

3. The injured employee's Social Security Number.

4. Tennessee Bureau of Workers' Compensation state file or claim number;

5. Date of injury;

6. Prescribing doctor's name;

7. Prescribing doctor's DEA number;

8. Name of drug and dosage;

9. Requestor's name (pharmacy or prescribing doctor);

10. Requestor's contact information;

11. A statement that the prior approval request for a previously prescribed and dispensed drug(s), which is excluded from the Closed Formulary, has been denied by the insurance carrier, accompanied by the denial letter if available;

12. A statement that an independent review request or request for reconsideration has already been submitted to the insurance carrier or the insurance carrier's utilization review agent;

13. A statement that the prior approval denial poses an unreasonable risk of a medical emergency and justification from a medical perspective such as withdrawal potential or other significant side effects or complications;

14. A statement that the potential medical emergency has been documented in the prior approval process;

15. A statement of justification from a medical perspective of the potential medical emergency such as withdrawal potential or other significant side effects or complications;

16. A statement that the insurance carrier has been notified that a request for an expedited determination is being submitted to the Bureau; and

17. The signature of the requestor and the following certification by the requestor for paragraphs 10 to 14 of this subsection, "I hereby certify under penalty of law that the previously listed conditions have been met."

(c) A request for an expedited determination under this section shall be processed and approved by the Medical Director of the Bureau in accordance with this section. At the discretion of the Medical Director of the Bureau, an incomplete request or a request with incomplete information for an expedited determination under this section may be considered in accordance with this section.

(d) The request for an expedited determination may be submitted on the designated form available on the Bureau of Workers' Compensation website. In the event the Bureau form is not available, the written request should contain the provisions of subsection (b) of this section.

(e) The requestor shall provide a copy of the request to the insurance carrier, prescribing doctor, injured employee, and dispensing pharmacy, if known, on the date the request is submitted to the Bureau.

(f) An expedited determination shall be effective retroactively to the date of the original prescription.

(13) A request for reconsideration of a prior approval denial is not required prior to a request for an expedited determination under this section. If, within 15 business days from the initial prior approval denial, a request for reconsideration or an expedited determination request is not initiated within 15 business days by the provider to the employer, carrier or utilization review agent and an expedited determination request is not communicated by the provider to the Medical Director of the Bureau at that time, then the opportunity to request an expedited determination under this section does not apply. Additionally, where a health care provider has sought relief from a previous adverse determination by requesting reconsideration by the employer, carrier, or utilization review agent and also by requesting an expedited

(Rule 0800-02-25-.04, continued)

determination by the Medical Director, the determination of the Medical Director shall prevail over the reconsideration determination of the employer, carrier, or utilization review agent.

(14) If pursuing an expedited determination after denial of a reconsideration request, a complete request shall be submitted within five business days of the notification of the reconsideration denial.

(a) An appeal of the utilization review organization decision relating to the medical necessity and reasonableness of the drugs contained in the expedited determination shall be submitted in accordance with these rules.

(b) The Medical Director's determination shall continue in effect until the later of:

1. Final determination of a medical dispute regarding the medical necessity and reasonableness of the drug;

2. Expiration of the period for a timely appeal; or

3. Agreement of the parties.

(c) Withdrawal of the request for an expedited determination by the requestor constitutes acceptance of the prior approval denial.

(d) All parties shall comply with an expedited determination issued in accordance with this section and the insurance carrier shall reimburse the pharmacy or other payer for prescriptions dispensed in accordance with the determination of the Medical Director.

(e) The insurance carrier shall notify the prescribing doctor, injured employee, and the dispensing pharmacy once reimbursement is no longer required because of the denial by the Medical Director of a request for an expedited determination.

(f) A decision issued by a utilization review organization is not a Bureau decision.

(g) A party may seek to reverse or modify the Medical Director's determination issued under this section if:

1. A final determination of medical necessity has been rendered; and

2. The party requests a hearing in accordance with the procedures of the Court of Workers' Compensation Claims.

3. The insurance carrier may dispute the request for expedited determination or the Medical Director's determination entered under this title by filing a written request for a hearing in accordance with the Court of Workers' Compensation Claims procedures.

Authority: *T.C.A. § 50-6-124.* ***Administrative History:*** *Original rule filed November 30, 2015; effective February 28, 2016.*