THE INDUSTRIAL COMMISSION OF ARIZONA

Treatment Guidelines: A.A.C. Title 20, Chapter 5, Article 13 Frequently Asked Questions

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EFFECTIVE DATE: This document is intended to address frequently asked questions regarding the Treatment Guidelines, including rule changes that go into effect ***on October 1, 2018***.

Introduction to the Treatment Guidelines

1. Why Did the Industrial Commission Implement the Treatment Guidelines (A.A.C. R20-5-1301 through R20-5-1312)?

In April 2012, Arizona lawmakers passed House Bill 2368, which required the Industrial Commission to "develop and implement a process for the use of evidence-based treatment guidelines, where appropriate, to treat injured workers." *See* A.R.S. § 23-1062.03.

2. What are the Treatment Guidelines?

The Treatment Guidelines are a series of twelve rules published in Title 20, Chapter 5, Article 13 of the Arizona Administrative Code. *See* A.A.C. R20-5-1301 through R20-5-1312. The Treatment Guidelines may be found at http://apps.azsos.gov/public_services/Title_20/20-05.pdf.

Among other things, the Treatment Guidelines: (1) prescribe the use of evidence-based medical treatment guidelines as a tool to support clinical decision making and quality health care delivery to injured employees within the context of Arizona's workers' compensation system; (2) adopt Work Loss Institute's *Official Disability Guidelines–Treatment in Workers Compensation* ("ODG") as the standard reference for evidence-based medicine; (3) outline a noncompulsory process for a medical provider or injured employee to seek preauthorization from a payer for medical services or treatment; (4) establish an administrative review process to help resolve disputes between medical providers/injured employees and payers; and (5) outline procedures for bringing unresolved disputes to the Industrial Commission for hearing.

The Treatment Guidelines and ODG are intended to improve the quality and outcomes of medical care in the context of Arizona's workers' compensation system and to improve the efficiency and effectiveness of the process under which medical care is provided to injured employees.

3. When did the Treatment Guidelines Go into Effect?

The Treatment Guidelines went into effect on October 1, 2016, but were initially limited to the management of chronic pain and the use of opioids for all stages of pain management. Effective October 1, 2018, the Treatment Guidelines will apply to all body parts and conditions that have been accepted as compensable.

4. Where Can I Find the Treatment Guidelines?

The Treatment Guidelines may be found at http://apps.azsos.gov/public_services/Title_20/20-05.pdf.

5. Does the Industrial Commission Have a Flowchart of the Treatment Guidelines Process?

Yes. The preauthorization, reconsideration, and administrative review process flowcharts may be found at https://www.azica.gov/divisions/medical-resource-office-mro.

The Official Disability Guidelines (ODG)

6. What is ODG?

ODG is a nationally-recognized, evidence-based, comprehensive, and multidisciplinary workers' compensation treatment guide. ODG helps set health policy in the workers' compensation setting by using evidence-based medicine to safeguard access to quality care while limiting excessive, unnecessary, ineffective, and harmful utilization of medical services.

To learn more about ODG, please visit ODG's website at https://www.worklassdata.com or to reach by phone please contact 800-488-5548.

7. Why did the Industrial Commission Adopt ODG?

The Industrial Commission conducted an extensive and independent evaluation of medical treatment guidelines commonly used in workers' compensation. Public hearings were held on the subject and ultimately the Industrial Commission adopted ODG as the standard of reference for evidence-based medicine to be used in treating injured employees in the Arizona workers' compensation system. ODG has been adopted by more states and provinces than any other treatment guideline.

By adopting and referencing the most recent ODG edition (at the time of treatment), the Industrial Commission seeks to ensure that current medical evidence is used to make treatment decisions for Arizona's injured employees.

8. To What Extent Has the Industrial Commission Adopted ODG?

The Treatment Guidelines went into effect on October 1, 2016, but the use of ODG was initially limited to the management of chronic pain and the use of opioids for all stages of pain management.

In 2017, the Industrial Commission studied the propriety of modifying the applicability of ODG pursuant to A.R.S. § 23-1062.03 and A.A.C. R20-5-1301(C). Under R20-5-1301(C), the Industrial Commission was authorized to "modify or change the applicability of the guidelines" if the Commission determined that modification or changing the applicability of the guidelines would: (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 relevant body parts or conditions.

On June 29, 2017, the Commission directed its Medical Resource Office to conduct an investigation and study regarding the three modification criteria. Consistent with the procedural requirements of R20-5-1301(C), the Commission publicly posted study materials and provided an opportunity for public comment. The Commission conducted a public hearing on November 30, 2017.

On December 21, 2017, following an evaluation of the study materials and stakeholder feedback, the Commission determined (at a public Commission meeting) that modifying the applicability of ODG to cover all body parts and conditions would improve medical treatment for injured workers and would make treatment and claims processing more efficient and cost effective. In addition, based upon written reviews received from board-certified physicians in Arizona (representing various specialties), the Commission determined that ODG adequately covers all body parts and conditions. Based on these determinations, the Commission took formal action to modify the applicability of ODG to all body parts and conditions, effective October 1, 2018.

9. Does ODG Apply to Supportive Care Awards?

As it pertains to the management of chronic pain and the use of opioids for all stages of pain management, ODG applies to medical care or services included in supportive care awards issued on or after October 1, 2016. Effective October 1, 2018, ODG applies to all other medical treatment or services included in supportive care awards.

For supportive care awards issued before October 1, 2016, that involve the management of chronic pain or the use of opioids or for supportive care awards issued before October 1, 2018, that involve other medical treatment or services, please consult an attorney to discuss whether the supportive care award may be modified.

10. Does ODG Apply Regardless of the Date of Injury?

Yes. ODG and the Treatment Guidelines apply to claims, regardless of the date of injury.

11. What is the Definition of "Chronic Pain" in the Treatment Guidelines?

For the purpose of the Treatment Guidelines, "chronic pain" is defined by ODG. ODG defines "chronic pain" as "pain that persists 30 days after the ODG Best Practice recommended disability duration for the diagnoses in question."

12. How Should a Medical Provider Use ODG When Treating an Injured Employee?

ODG should be used as a tool to support clinical decision making and quality health care delivery to injured employees. ODG sets forth care that is generally considered reasonable and is presumed correct if the guidelines provide recommendations related to the requested treatment or service.

13. Can a Medical Provider Deviate from ODG?

ODG sets forth care that is generally considered reasonable and is presumed correct if the guidelines provide recommendations related to the requested treatment or service. The presumption of correctness is rebuttable and medical care may, where appropriate, include deviations from ODG. To support a deviation from ODG, a provider must be able to produce documentation and justification that demonstrates by a preponderance of the credible medical evidence a medical basis for departing from ODG. A "preponderance of the credible medical evidence" means that there is enough evidence to make it more likely than not that there is a medical basis for departing from ODG. Credible medical evidence may include clinical expertise and judgment.

14. Can a Payer Decline to Pay for Provided Treatment or Services Supported by ODG?

ODG sets forth care that is generally considered reasonable and is presumed correct if the guidelines provide recommendations related to the requested treatment or service. A payer can decline to pay for provided treatment or services supported by ODG *only if* the payer can rebut the presumption of 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.

Disputes related to a payer's failure to pay for provided treatment or services may be processed as a request for investigation and hearing under A.R.S. § 23-1061(J). To request review under A.R.S. § 23-1061(J), *the injured employee* must file a request for hearing with the Industrial Commission. The request for hearing form may be found at https://www.azica.gov/forms.

15. How is ODG Organized?

ODG is divided into chapters, each based on specific body parts (such as "knee and leg") or general conditions (such as "pain"). Each chapter has a "Procedure Summary" section which includes a comprehensive list of treatments that might apply to an injury to the applicable body part or that might be used to treat the applicable condition. Treatment procedures are designated as "recommended," "not recommended," or "under study." All recommendations are based on comprehensive and ongoing medical literature reviews. Treatment recommendations are linked to supporting medical evidence, provided in abstract form, which has been ranked, highlighted, and indexed. Full text copies of supporting medical studies are also available.

16. Who Develops and Authors ODG?

An editorial advisory board composed of approximately 100 health-care professionals develops and authors ODG. The advisory board is multidisciplinary in scope, representing all medical specialties (occupational medicine, orthopaedic surgeons, physical therapists, chiropractors, etc.). ODG is continuously updated based on the most-current medical evidence. The advisory board does not represent the interests of any one provider group over others.

ODG guidelines are developed according to the AGREE Instrument. AGREE stands for "Appraisal of Guidelines Research and Evaluation." AGREE originates from an international collaboration of researchers and policy makers who work together to improve the quality and effectiveness of clinical practice guidelines by establishing a shared framework for their development, reporting, and assessment. For more information about ODG Methodology Using the AGREE Instrument, visit https://www.worklossdata.com.

17. How Often is ODG Updated?

ODG is continuously updated, reflecting the findings of new studies as they are conducted and released. In addition, ODG undergoes a comprehensive annual update process based on scientific medical literature review, claims data analysis, and expert panel validation.

18. How Can I Access ODG?

ODG is available on a subscription-basis. Additional information on ODG subscriptions is available on the ODG website: http://www. worklossdata.com. Individuals or companies can purchase annual licenses to access the legacy web-based interface or the new web-based interface launched in April 2018 (ODG by MCG). ODG is also available for integration into other software platforms. Subscription licenses are available to:

- Health-care providers;
- Attorneys; or
- Insurance carriers, third-party administrators, self-insured employers.

The cost for a single-user (medical providers or attorneys) license is $599.00. Use coupon code ODGAZ for a 50% discount. Please call 800-488-5548 to order.

19. How Do I Navigate and Use ODG?

The following Arizona-specific training webinars provide an introduction to ODG and the Treatment Guidelines. The webinars illustrate how to navigate and interpret ODG and the ODG Drug Formulary:

ODG Training for Arizona (July 26, 2016).
ODG Training for Arizona (August 2, 2016).

ODG by MCG Training for Arizona (Coming August 2018)
ODG: Good to Go!

The recorded webinars above and links to other Treatment Guidelines resources may be found at https://www.azica.gov/divisions/medical-resource-office-mro.

An additional webinar ("Introducing the New ODG by MCG") regarding ODG's new web-based platform is available from ODG at: http://www.worklossdata.com/.

ODG Drug Formulary

20. Is the ODG Drug Formulary Applicable in Arizona?

Yes. Effective October 1, 2018, Appendix A, ODG Workers' Compensation Drug Formulary will be applicable to all body parts and conditions that have been accepted as compensable.

21. What are "Y" and "N" Drugs in the ODG Drug Formulary?

The ODG Drug Formulary designates each drug class as a "Y" drug or an "N" drug. A "Y" drug is a preferred drug (*i.e.*, a first-line drug). An "N" drug is not recommended as a first-line treatment by ODG. "N" does not mean "No." Instead, "N" drugs need to be substantiated as appropriate and medically necessary.

22. Can a Payer Immediately Stop Authorizing Medications that are Not Supported by ODG or the ODG Drug Formulary?

The intent of the Treatment Guidelines is **not** to immediately deny employees medications already in use, **even where** the medications are not recommended by ODG. Because medications can involve dependency and addiction issues, drug rehabilitation and/or detoxification treatment may be necessary. ODG recommends weaning when evidence exists of substance misuse, abuse, or addiction. Consult ODG for further information regarding recommended weaning protocols for particular medications.

In the event a dispute arises regarding the necessity or propriety of drug rehabilitation and/or detoxification treatment, payers should continue to provide the disputed medication until a final determination is made, either in the administrative review process or by an Administrative Law Judge. *See* A.R.S. § 23-1062.02(F).

The Preauthorization Process

23. Who is a "Payer" Under the Treatment Guidelines?

A "payer" includes: (1) an insurance carrier defined under A.R.S. § 23-901; (2) a self-insured employer defined under A.A.C. R20-5-102; (3) a third-party administrator; or (4) the Special Fund of the Industrial Commission.

24. What is Preauthorization?

Preauthorization is a written request made by a medical provider (using Section I (Provider Request for Preauthorization) of the MRO-1.1 Medical Treatment Preauthorization Form) to a payer, requesting approval to provide specified medical treatment or services to an injured employee. The MRO-1.1 Medical Treatment Preauthorization Form and Instructions may be found at https://www.azica.gov/forms.

25. Are Medical Providers Required to Request Preauthorization Before Providing Medical Treatment or Services to an Injured Employee?

No. Preauthorization is not required to ensure payment for reasonably required medical treatment or services. Although preauthorization is not required, providers are permitted to seek preauthorization to obtain pre-approval from a payer for a medical treatment or service. Pre-approval ensures that a provider will be paid for treatment or services rendered and permits a provider to avoid the risk that a payer will deny payment on grounds that a treatment or service was not reasonably required and appropriate under ODG or on grounds that there is a medical contraindication or significant medical or psychological reason not to pay for the treatment or services supported by ODG.

Effective October 1, 2018, requests for preauthorization must be in writing using Section I (Provider Request for Preauthorization) of the MRO-1.1 Medical Treatment Preauthorization Form. The MRO-1.1 Medical Treatment Preauthorization Form and Instructions may be found at https://www.azica.gov/forms. Requests for preauthorization must be submitted **to a payer** by mail, electronically, or fax.

26. Which Drugs on the ODG Drug Formulary are Subject to Preauthorization?

Preauthorization is not required to ensure payment for reasonably required medical treatment or services, including medication. Although preauthorization is not required, medical providers are permitted to seek preauthorization to obtain pre-approval from a payer for prescriptions. Pre-approval ensures that a provider will be paid for the medication and helps avoid the risk that a payer will deny payment on grounds that the medication was not reasonably required and appropriate under ODG or on grounds that there is a medical contraindication or significant medical or psychological reason not to pay for a medication supported by ODG, especially for medications designated as "N" drugs in the ODG Drug Formulary.

The ODG Drug Formulary designates each drug class as a "Y" drug or an "N" drug. A "Y" drug is a preferred drug (a first-line drug). An "N" drug is not recommended as a first-line treatment in ODG. "N" does not mean "No." Instead, "N" drugs need to be substantiated as appropriate and medically necessary.

As a practical matter, many pharmacies have connectivity with payers through a pharmacy benefit manager (PBM). Pharmacies will frequently request preauthorization for medications in order to confirm they will be paid for those medications before they dispense. When a request for preauthorization is received by a payer, either directly or through a PBM, the payer (or their PBM)

may approve or deny the request (in whole or in part). Requests for preauthorization of medication follow the same procedure as requests for preauthorization for other medical treatment or services.

Effective October 1, 2018, requests for preauthorization must be in writing using Section I (Provider Request for Preauthorization) of the MRO-1.1 Medical Treatment Preauthorization Form. The MRO-1.1 Medical Treatment Preauthorization Form and Instructions may be found at https://www.azica.gov/forms. Requests for preauthorization may be submitted **to a payer** by mail, electronically, or fax.

27. How Do I Submit a Preauthorization Request to a Payer?

Effective October 1, 2018, a provider **must** submit a request for preauthorization in writing using Section I (Provider Request for Preauthorization) of the MRO-1.1 Medical Treatment Preauthorization Form. A provider must attach documentation to a request for preauthorization that supports the medical necessity and appropriateness of the treatment or services requested, such as office notes and diagnostic reports. Preauthorization requests may be submitted by mail, electronically, or by fax directly to a payer. **Providers should not submit preauthorization requests to the Industrial Commission**.

The MRO-1.1 Medical Treatment Preauthorization Form and Instructions may be found at https://www.azica.gov/forms.

28. Can a Payer Deny a Preauthorization Request or Refuse to Make Payment for a Provided Treatment or Service Solely Because ODG Does Not Address the Requested Treatment or Service?

No. A payer may not deny or decline to pay for reasonably required medical treatment or services solely because ODG does not address the requested treatment or service.

29. Can a Payer Deny a Preauthorization Request Supported by ODG?

ODG sets forth care that is generally considered reasonable and is presumed correct if the guidelines provide recommendations related to the requested treatment or service. A payer may deny a preauthorization request supported by ODG **only if** the payer can rebut the presumption of 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.

Where a payer denies a preauthorization request for a treatment or service supported by ODG, the medical provider or injured worker may bypass the reconsideration process and immediately request administrative review from the Industrial Commission (unless the payer obtained an IME in support of its denial, *see* below).

If a payer obtains an IME in support of its denial, review of the payer's decision will be processed as a request for investigation under A.R.S. § 23-1061(J). To request review under A.R.S. § 23-

1061(J), *the injured employee* must file a request for hearing with the Industrial Commission. The request for hearing form may be found at https://www.azica.gov/forms.

30. Can a Payer Authorize Requested Treatment or Services in Part and Deny Requested Treatment or Service in Part?

Yes. Where appropriate, payers should approve preauthorization requests to the extent the requested treatment or services are reasonably required. Payers should not deny entire preauthorization requests simply because some part of the requested treatment or services are not reasonably required or not supported by ODG.

31. Can a Payer Change a Decision to Deny Requested Treatment or Services?

Yes. A payer can reverse its decision to deny treatment or services at any time through the preauthorization and/or administrative review process. A payer's authorization of a requested treatment or service ends the preauthorization process.

32. What Happens After a Preauthorization Request is Submitted to a Payer?

Effective October 1, 2018, a payer is required to respond to a complete preauthorization request **within 7 business days** after the request is received. To insure timely processing, payers are encouraged to establish effective processes for receiving and reviewing preauthorization requests.

Effective October 1, 2018, a payer must respond to preauthorization requests by using Section II (Payer Decision on Request for Preauthorization) of the MRO-1.1 Medical Treatment Preauthorization Form. The payer's response should be sent to the provider using the provider's preferred method of contact (as indicated by the provider in Section I of the MRO-1.1 Medical Treatment Preauthorization Form).

The payer's response to a request for preauthorization may include one of the following:

> (1) Preauthorization decision. The payer's response to a request for preauthorization can approve, deny, or partially approve and partially deny requested medical treatment or services. The decision must be made using Section II (Payer Decision on Request for Preauthorization) of the MRO-1.1 Medical Treatment Preauthorization Form. A payer must attach to its response a statement of the approved treatment or services or, if not approved, the reasons supporting a denial/partial denial. If requested treatment or services are denied, the payer must provide a copy of its preauthorization decision to the injured employee or, if represented, to the injured employee's authorized representative.
>
> (2) Notification to the provider that the preauthorization request is incomplete. Upon receipt and identification of a deficient request for preauthorization – either because the request was not submitted using Section I (Provider Request for Preauthorization) of the MRO-1.1 Medical Treatment Preauthorization Form or because a request submitted on Section I of the MRO-1.1 Medical Treatment Preauthorization Form is incomplete – a payer may choose to either: (a) render a decision on the request (*see* (1) above); or (b)

provide written notice to the provider that the request is incomplete by using Section II (Payer Decision on Request for Preauthorization) of the MRO-1.1 Medical Treatment Preauthorization Form. A payer **must** either render a decision on an incomplete preauthorization request or provide notice to the provider of a deficiency **within 7 business days** after an incomplete preauthorization request is received and identified. A provider may cure a defect in a preauthorization request and resubmit a corrected request to the payer (and thereby restart the process).

(3) Notification to the provider that an IME has been requested under Arizona Administrative Code R20-5-114. Where a payer requests an IME after receiving a preauthorization request, the payer should notify the provider **within 7 business days** after the request is received that an IME has been requested using Section II (Payer Decision on Request for Preauthorization) of the MRO-1.1 Medical Treatment Preauthorization Form. Where a payer requests an IME, the time for rendering a preauthorization decision (under (1) above) is suspended. In this circumstance, the payer's decision on a preauthorization request must be issued no later than **7 business days** after the final IME report has been received by the payer. The payer is required to provide a copy of the final IME report to the provider upon receipt of the report.

Where a payer obtains an IME in support of its decision, review of the payer's decision will be processed as a request for investigation under A.R.S. § 23-1061(J). To request review under A.R.S. § 23-1061(J), *the injured employee* must file a request for hearing with the Industrial Commission. The request for hearing form may be found at https://www.azica.gov/forms.

The MRO-1.1 Medical Treatment Preauthorization Form and Instructions may be found at https://www.azica.gov/forms.

33. Who Should Receive a Copy of the Payer's Preauthorization Decision?

A payer should provide a copy of its written preauthorization decision to the requesting provider and, if requested treatment or services are denied, to the injured employee and, if applicable, their authorized representative.

34. What if a Payer Does Not Respond to a Preauthorization Request?

If a payer does not communicate its preauthorization decision **within 7 business days after the request is received**, the payer's non-action is deemed a "no response" and the provider or injured employee may bypass the reconsideration process and immediately request administrative review from the Industrial Commission.

In addition, a payer's failure to comply with the required time limits may be considered unreasonable delay under Arizona Administrative Code R20-5-163.

35. Can a Payer Delegate Preauthorization Decision-Making to an Agent, Such as a Third-Party Administrator or Pharmacy Benefits Manager?

Yes. However, any preauthorization or reconsideration decision by a payer's agent, including a third-party administrator or pharmacy benefits manager, is binding on the payer. Payers cannot avoid responsibility under the Treatment Guidelines by delegating decision-making authority to an agent.

36. Can a Payer Require that Preauthorization Requests be Submitted Directly to an Agent of the Payer, such as a Third-Party Administrator or Pharmacy Benefits Manager?

No. Payers may ask, but cannot require medical providers to submit preauthorization requests to the payer's agent, such as a third-party administrator or pharmacy benefits manager. Payers may not reject or ignore preauthorization requests simply because they are submitted to the payer, rather than the payer's authorized agent. Payers who delegate review authority to an agent should establish an effective process for promptly forwarding preauthorization requests to the payer's designated agent. The deadlines imposed by the Treatment Guidelines are not suspended when a request is submitted to a payer who then forwards the request to its agent for review and decision.

The Reconsideration Process

37. If a Payer Has Denied a Preauthorization Request, is a Medical Provider or Injured Employee Required to Ask the Payer to Reconsider its Decision?

Generally, an injured employee or medical provider must seek reconsideration of a payer's decision to deny requested medical treatment or services before requesting administrative review from the Industrial Commission.

Where a payer obtained an IME in support of its decision, a request for reconsideration is permissible, but not required. Review of the payer's decision in these circumstances will be processed as a request for investigation under A.R.S. § 23-1061(J). To request review under A.R.S. § 23-1061(J), *the injured employee* must file a request for hearing with the Industrial Commission. The request for hearing form may be found at https://www.azica.gov/forms.

Where the payer denies a preauthorization request for a treatment or service **supported by ODG**, the medical provider or injured worker may bypass the reconsideration process and immediately request an administrative review from the Industrial Commission (unless the payer obtained an IME in support of its denial).

If a payer does not communicate its preauthorization decision **within 7 business days** of receiving the request, the payer's non-action is deemed a "no response" and the provider or injured employee may bypass the reconsideration process and immediately request administrative review from the Industrial Commission.

38. How Do I Submit a Request for Reconsideration to a Payer?

Reconsideration requests must be in writing using Section III (Provider or Employee Request for Reconsideration of Payer Decision) of the MRO-1.1 Medical Treatment Preauthorization Form, and must attach the specific reasons and justifications to support reconsideration. If not previously provided, the injured employee or provider must also include supporting medical documentation with a request for reconsideration. Reconsideration requests should be sent to the payer using the payer's preferred method of contact (as indicated by the payer in Section II of the MRO-1.1 Medical Treatment Preauthorization Form). **Providers should not submit reconsideration requests to the Industrial Commission.**

The MRO-1.1 Medical Treatment Preauthorization Form and Instructions can be found at https://www.azica.gov/forms.

39. What Happens After a Reconsideration Request is Submitted to a Payer?

Effective October 1, 2018, a payer is required to respond to a reconsideration request **within 7 business days** after the request is received. To insure timely processing, payers are encouraged to establish effective processes for receiving and reviewing reconsideration requests.

Effective October 1, 2018, a payer must respond to a reconsideration request by using Section IV (Payer Decision on Request for Reconsideration) of the MRO-1.1 Medical Treatment Preauthorization Form. The payer's response should be sent to the provider using the provider's preferred method of contact (as indicated by the provider in Section I of the MRO-1.1 Medical Treatment Preauthorization Form).

The payer's response to a request for reconsideration may include one of the following:

(1) Reconsideration decision. The payer's response to a request for reconsideration may approve, deny, or partially approve and partially deny requested medical treatment or services. The decision must be made using Section IV (Payer Decision on Request for Reconsideration) of the MRO-1.1 Medical Treatment Preauthorization Form. A payer must also attach to its response a statement of the approved treatment or services or, if not approved, the reasons supporting a denial/partial denial. If requested treatment or services are denied, the payer must provide a copy of its decision to the injured employee or, if represented, to the injured employee's authorized representative.

(2) Notification to the provider that an IME has been requested under Arizona Administrative Code R20-5-114. Where a payer requests an IME after receiving a reconsideration request, the payer should notify the provider **within 7 business days** after the request is received that an IME has been requested using Section IV (Payer Decision on Request for Reconsideration) of the MRO-1.1 Medical Treatment Preauthorization Form. Where a payer requests an IME, the time for rendering a reconsideration decision (under (1) above) is suspended. In this circumstance, the payer's decision on a reconsideration request must be issued no later than **7 business days** after the final IME

report has been received by the payer. The payer is required to provide a copy of the final IME report to the provider upon receipt of the report.

Where a payer obtains an IME in support of its decision, review of the payer's decision will be processed as a request for investigation under A.R.S. § 23-1061(J). To request review under A.R.S. § 23-1061(J), *the injured employee* must file a request for hearing with the Industrial Commission. The request for hearing form may be found at https://www.azica.gov/forms.

The MRO-1.1 Medical Treatment Preauthorization Form and Instructions may be found at https://www.azica.gov/forms.

40. Who Should Receive a Copy of the Payer's Reconsideration Decision?

A payer should provide a copy of its written reconsideration decision to the requesting provider and, if requested treatment or services are denied, to the injured employee, and, if applicable, their authorized representative.

41. What if a Payer Does Not Respond to a Reconsideration Request?

If a payer fails to communicate its reconsideration decision to the requesting provider **within 7 business days** after the request is received, the provider or injured employee may immediately request administrative review from the Industrial Commission.

In addition, a payer's failure to comply with the required time limits may be considered to be unreasonable delay under Arizona Administrative Code R20-5-163.

42. Can a Payer Delegate Reconsideration Decisions to an Agent, Such as a Third-Party Administrator or Pharmacy Benefits Manager?

Yes. However, any preauthorization or reconsideration decision by a payer's agent, including a third-party administrator or pharmacy benefits manager, is binding on the payer. Payers cannot avoid responsibility by delegating decision-making authority to an agent.

43. Can a Payer Require that Reconsideration Requests be Submitted to an Agent of the Payer, Such as a Third-Party Administrator, Review Organization, or Pharmacy Benefits Manager?

No. Payers may ask, but cannot require injured employees or medical providers to submit reconsideration requests to the payer's agent, such as a third-party administrator, review organization, or pharmacy benefits manager. Payers may not reject reconsideration requests simply because they are submitted to the payer, rather than the payer's agent. Payers who delegate review authority to an agent should establish an effective process for promptly forwarding reconsideration requests to the payer's designated agent. The deadlines imposed by the Treatment

Guidelines are not suspended when a request is submitted to a payer who then forwards the request to an agent for consideration and decision.

The Administrative Review Process

44. What is an Administrative Review?

Administrative review is a process that includes a peer review of a denied or partially denied request for preauthorization/reconsideration. The administrative review process is administered by the Industrial Commission's Medical Resource Office.

Effective October 1, 2018, the administrative review process applies to medical treatment or services related to all body parts and conditions that have been accepted as compensable.

45. Who Can Request Administrative Review From the Industrial Commission?

A medical provider, injured employee, or their authorized representative may request administrative review by the Industrial Commission in the following circumstances:

(1) The payer failed to timely respond to a medical provider's preauthorization or reconsideration request.

(2) The payer denied a preauthorization request for a medical treatment or service supported by the ODG.

(3) The payer denied a reconsideration request for a medical treatment or service.

If a payer obtained an IME in support of its decision, administrative review is not available. Review of a payer's decision in these circumstances will be processed as a request for investigation under A.R.S. § 23-1061(J). To request review under A.R.S. § 23-1061(J), *the injured employee* must file a request for hearing with the Industrial Commission. The request for hearing form may be found at https://www.azica.gov/forms.

46. What is Required to Request Administrative Review?

The Industrial Commission's Medical Resource Office will screen all requests for administrative review to determine whether administrative review is appropriate. To qualify for administrative review, the following criteria must be satisfied:

- The requesting party is either the medical provider or an injured employee.
- The relevant body part and/or condition has been accepted as compensable.
- A preauthorization request has been submitted to the payer.

- The preauthorization request has been denied, in whole or in part, or the payer has failed to respond to the preauthorization request in a timely manner.

- A request for reconsideration has been submitted to the payer (**only required if**: (1) the payer timely responded to the preauthorization request; and (2) the preauthorization denial was supported by ODG).

- The payer's preauthorization or reconsideration decision was not supported by an IME.

If any of the foregoing requirements are not satisfied, administrative review is unavailable.

47. Can Payers Request Administrative Review?

No. Only an injured employee, their authorized representative, or a provider may seek administrative review. Payers have the authority to render decisions regarding requested medical treatment or services and may not seek administrative review to resolve disputes regarding requested medical treatment or services. Payers, however, may request IMEs to assist in rendering decisions regarding requested medical treatment or services.

48. Can Administrative Review Be Requested When a Payer's Decision is Supported by an IME?

No. If the payer obtains an IME in support of its decision, administrative review is not available. Review of the payer's decision in these circumstances will be processed as a request for investigation under A.R.S. § 23-1061(J). To request review under A.R.S. § 23-1061(J), *the injured employee* must file a request for hearing with the Industrial Commission. The request for hearing form may be found at https://www.azica.gov/forms.

49. How Do I Submit a Request for Administrative Review?

Requests for administrative review must be in writing using Section V (Provider or Employee Request for Administrative Review) of the MRO-1.1 Medical Treatment Preauthorization Form, and must attach: (1) copies of all relevant medical records and (if applicable) documentation related to the payer's non-response; and (2) copies of all documentation and statement previously attached to Sections I-IV of the MRO-1.1 Medical Treatment Preauthorization Form. The MRO-1.1 Medical Treatment Preauthorization Form and Instructions can be found at https://www.azica.gov/forms.

Requests for administrative review may be submitted electronically through the MRO Portal at https://mro.azica.gov.

Alternatively, requests for administrative review may be faxed to (602)-542-4797, e-mailed to MRO@azica.gov, or mailed to:

Industrial Commission of Arizona
Medical Resource Office
800 West Washington Street
Phoenix, AZ 85007

50. What Happens After a Request for Administrative Review is Submitted to the Industrial Commission?

Upon receipt for a request for administrative review, the Industrial Commission's Medical Resource Office will screen the request to determine whether administrative review is available. To qualify for administrative review, the following criteria must be satisfied:

- The requesting party is either the medical provider or an injured employee.
- The relevant body part and/or condition has been accepted as compensable.
- A preauthorization request has been submitted to the payer.
- The preauthorization request has been denied, in whole or in part, or the payer has failed to respond to the preauthorization request in a timely manner.
- A request for reconsideration has been submitted to the payer (**only required if**: (1) the payer timely responded to the preauthorization request; and (2) the preauthorization denial was supported by ODG).
- The payer's preauthorization or reconsideration decision was not supported by an IME.

If any of the foregoing requirements are not satisfied, administrative review is unavailable and the Industrial Commission will send a notice to the injured employee and payer (within three business days), advising that administrative review is not available.

If the foregoing requirements are satisfied, the Industrial Commission will send a notice to the payer within three business days advising that it has received the request for administrative review. The notice will provide information on how to participate in the administrative review process.

51. Who Performs an Administrative Review?

Administrative review consists of a peer review performed by an individual that holds an active, unrestricted license or certification to practice medicine or a health profession. The peer reviewer must have actively practiced medicine or a health profession during the five preceding years. "Active practice" means performing patient care for a minimum of eight hours per week in one of the five preceding years. The peer reviewer must also be in the same profession and the same specialty or subspecialty as typically performs or prescribes the medical treatment or services requested. Finally, the peer reviewer must be licensed in Arizona, unless the Industrial Commission or its peer review contractor is unable to find such an individual.

Currently, the Industrial Commission has contracted with the following URAC accredited peer-review vendors:

- CompPartners.
- Maximus.

The Industrial Commission has implemented a robust conflicts check to ensure that administrative review determinations are fair and impartial.

52. Who Pays for an Administrative Review?

The payer is responsible for paying the costs of the peer review performed by the URAC accredited peer-review vendor.

53. What is the Cost of an Administrative Review?

The current fee schedules for peer review are as follows:

Expedited Reviews
Up to 60 pages: $325.00
Up to 199 pages: $400.00
Over 200 pages: $550 .00

Standard Reviews
Up to 60 pages: $250.00
Up to 199 pages: $325.00
Over 200 pages: $475.00

Peer reviews terminated or dismissed before forwarding to a medical reviewer: $100.00.

Peer reviews terminated or dismissed after forwarding to a medical reviewer: $250.00.

54. What is Involved in a Peer Review?

The peer review will consist of a records review and, when possible, a consultation between the medical provider and the peer reviewer. The peer reviewer must make a good faith effort to contact the provider requesting the preauthorization. The good faith effort must 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.

55. Can a Provider Bill a Payer for Time Spent Participating in a Peer-to-Peer Conversation With the Individual Conducting the Peer Review?

Yes. Arizona's Physicians' Fee Schedule includes codes for time spent participating in a peer-to-peer consultation with an individual conducting a peer review. Code AZ099-001 ($75.00)

should be used for a peer-to-peer consultation lasting between 5-10 minutes. Code AZ099-002 ($100.00) should be used for a peer-to-peer consultation lasting between 11-30 minutes.

56. During the Administrative Review, Can the Industrial Commission or Peer Review Vendor Request Additional Information or Documentation from the Provider, Injured Employee, or Payer?

Yes. A medical provider, injured employee, their authorized representative, or payer must cooperate and provide the Industrial Commission or the peer-review vendor any necessary medical information, including information pertaining to the payer's decision.

57. What is the Timeframe for Completing an Administrative Review?

Administrative review determinations should be issued within two to three weeks from the date of receipt of the request for administrative review. The peer review vendor will send the administrative review determination to the injured employee (or their representative), the provider, and the payer.

58. What is Included in the Administrative Review Determination?

An administrative review determination must include the information listed in Arizona Administrative Code R20-5-1311(K).

59. Who Should Receive a Copy of an Administrative Review Determination?

The payer, injured employee, their authorized representative (if applicable), and the provider should be provided a copy of the administrative review determination.

Post-Administrative Review

60. Can an Administrative Review Determination Be Contested?

Yes. An interested party (defined by A.R.S. § 23-901 to include the employer, employee, and insurance carrier [or their representative]) dissatisfied with the administrative review determination may request that the dispute be referred to the Industrial Commission's Administrative Law Judge Division for hearing.

The request for hearing must be in writing, be filed no later than 10 business days after the administrative review determination is issued, and state whether the party requests to participate in the Fast Track ALJ Dispute Resolution Program by stipulation.

The request for hearing form may be found at https://www.azica.gov/forms.

61. What is the Effect of the Administrative Review Determination if it is Contested?

If a timely request for hearing is filed, the administrative review determination is deemed null and void and will serve no evidentiary purpose. The administrative review determination will be inadmissible and testimony concerning the administrative review determination will have no evidentiary value.

ODG is generally considered reasonable and is presumed correct. In practice, if denied medical treatment or services are supported by ODG, the payer will have the burden of rebutting the presumption of correctness with documentation and justification that demonstrates by a preponderance of the credible medical a medical basis for departing from ODG.

The same is true for denied medical treatment or services not supported by ODG. In this circumstances, the injured employee will have the burden of rebutting the presumption of correctness by demonstrating by a preponderance of the credible medical evidence a medical basis for deviating from ODG. Credible medical evidence may include clinical expertise and judgment.

62. What is the Fast Track ALJ Dispute Resolution Program?

The Fast Track ALJ Dispute Resolution Program is a voluntary dispute-resolution program designed to expedite review of contested administrative review determinations. The following are elements of the program:

- Parties must agree to participate in the program with the understanding that a short form decision will be issued.
- Review by the presiding Administrative Law Judge (ALJ) will be limited to the treatment or service dispute considered during the administrative review process.
- The presiding ALJ will issue a notice of hearing within ten business days of the receipt of the fully-executed agreement to participate and certificate of readiness.
- The hearing will be held within 30 calendar days from the day that the notice of hearing is issued, to the extent practicable.
- Discovery will be limited to five interrogatories and no depositions will be permitted.
- The presiding ALJ shall take all lay witness testimony at the time of the hearing and will not hold further hearings.
- The presiding ALJ shall consider documentary medical evidence only; no medical testimony will be taken.
- Medical file review opinions will be deemed to constitute substantial evidence to support the requested treatment or service.

- All documentary evidence must be submitted no later than ten business days before the schedule hearing.

- The hearing will be recorded, but not transcribed, unless a party files a request for review under A.R.S. §§ 23-942 and 23-943.

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