HOOVER REHABILITATION SERVICES, INC.

TENNESSEE UTILIZATION REVIEW PROGRAM

HOOVER REHABILITATION SERVICES, INC.
1970 Technology Parkway, Mechanicsburg, PA 17050
Toll Free 1.800.692.7294
Visit www.hooverinc.com

TABLE OF CONTENTS

Tennessee Utilization Review Program:

As provided in Chapter 0800-02-06, General Rules of the Workers' Compensation Program Utilization Review Rules promulgated by the Tennessee Department of Labor and Workforce Development, Bureau of Worker's Compensation, Hoover Rehabilitation Services, Inc. (Hoover) provides the following information regarding its plan for Utilization Review:

Hoover Rehabilitation Services, Inc.
1970 Technology Parkway
Mechanicsburg, PA 17050

Telephone: (800) 692-7294
Fax: (717) 728-5505

Web Address: www.hooverinc.com

Normal Business Hours: 8:30 AM to 4:30 PM Eastern Standard Time

Utilization Review Department Contact:

Telephone: (877) 704-4440
Fax: (570) 283-1637

Definition of Utilization Review:

As defined in Chapter 0800-02-06, Utilization Review is the evaluation of the necessity, appropriateness, efficiency, and quality of medical services, to include the prescription of one or more Schedule II, III, or IV controlled substances for pain management for a period of time exceeding 90 days from the initial prescription of the controlled substances, based upon medically-accepted standards and an objective evaluation of medical services provided.

Overview of the Utilization Review Process:

If an authorized treating physician's recommended treatment cannot be approved by an employer or the claims adjuster, the employer/adjuster may seek another opinion from a physician of the same specialty, by making a review request through a certified Utilization Review Agent (URO), to have a physician of same or similar specialty review and address medical necessity. When recommended treatment is not certified or approved, Denials must be based upon the Official Disability Guidelines (ODG) by MCG, which are independent, evidence-based guidelines for treating common work injuries.

Mandatory Utilization Review:

- If the employer (as defined in 0800-02-06) disagrees with the authorized treating physician regarding the recommended treatment.

- If it is mandated by T.C.A. Section 50-6-124, or the Bureau's Rules for Medical Payment, Medical Fee Schedule, or In-Patient Hospital Fee Schedule rules contained in Chapters 0800-02-17, 0080-02-18, and 0800-02-19 (Inpatient hospital admissions and non-emergency ground and air ambulance services).

Hoover's Utilization Review Procedure and Process:

1. Hoover receives a referral from the insurance carrier, third party administrator, or employer who shall provide all medical documentation to the Hoover UR representative for review.

2. **The employer/adjuster shall respond to the requesting provider within four (4) business days of a receipt of a request for treatment, referral, second opinion, or consult**. The four (4) business day interval begins when the employer/adjuster receives the medical record that corresponds in time to the date of the treatment request.

3. If the adjuster does not approve the request within four (4) business days, the adjuster shall immediately send the request to the Utilization Review Organization and notify all parties.

4. Upon referral of the case for utilization review, within 3 business days, Hoover Utilization Review personnel complete and electronically file Form C-35 (**EXHIBIT 1** – Utilization Review Notification Form LB-0380 Tennessee Department of Labor & Workforce Development/Division of Workers' Compensation) and submit the form to the Tennessee Department of Labor & Workforce Development/Division of Workers' Compensation.

5. The adjuster shall send to the utilization review organization all pertinent medical records corresponding to tests or treatments paid for by the insurer in the past twelve (12) months and any communications necessary for the Utilization Review Organization to complete its determination. This shall include but not limited to Form C35-A (**EXIBIT 2** – Notice of Appeal Rights for a Utilization Review Denial) containing current and complete information of the employer, the names, and contact information for the injured worker, the adjuster, the adjuster's supervisor, the compliance contact, and the attorneys. If there is no existing compliance contact email, the email for the adjuster's supervisor, the office manager or other liaison shall be listed. The medical records shall be in chronological or reverse chronological order, free of duplicates, one-sided, free of fax confirmation sheets and free of billing statements. The organization of the medical records may be accomplished by the Utilization Review Organization. The employer may be subject to sanctions and/or civil penalties pursuant to Rule 0800-02-06-.10 of this Chapter.

Hoover Response to a Utilization Review Request:

The Hoover UR representative reviews all available medical documentation and cross references nationally-accepted criteria, for the diagnosis and relevant information and data contained in the Official Disability Guidelines (ODG).

In compliance with T.C.A. Section 56-6-705 (2), appearing below are the written, evidence-based clinical criteria utilized by Hoover Rehabilitation Services to identify medical necessity or appropriateness of health care services. Information is available on our web site at **www.hooverinc.com .**

T.C.A. Section 56-6-705 (2):

(A) Any restrictions, pre-authorizations, adverse determinations, or final adverse determinations that Hoover places on the pre-authorization of health care services will be based on the medical necessity or appropriateness of those services and will be based on written clinical criteria.

(B) Hoover applies nationally-recognized written clinical criteria consistently based on the ODG guidelines; however, when multiple standards address the same treatment protocols, the payer will have the right to select the standard upon which the written clinical criteria will be based.

If Hoover develops any new standards pursuant to § 50-6-124, standards will be evidence-based to ensure quality of care and access to needed health care services, and Hoover will cite standards being utilized and reference the specific section of the standards. Any new standards will be evaluated and updated at least annually, and appear on Hoover's web portal at www.hooverinc.com.

If Hoover intends to either implement a new preauthorization requirement or restriction, or amend an existing requirement or restriction, Hoover will provide contracted health care providers with written notice, or other form of notice under the terms of the contract, of the new or amended requirement or restriction no less than sixty (60) days before the requirement or restriction is implemented and shall ensure that such restriction or requirement has been updated on the Hoover's web site.

The Tennessee Bureau of Workers' Compensation has adopted the Work Loss Data Institute ODG® Guidelines for the criteria used to determine the recommended treatments for injured workers in the state of Tennessee.

https://www.tn.gov/workforce/injuries-at-work/bureau-services/bureau-services/medical-programs-redirect/medical-treatment-guidelines.html

Hoover Review Nurses utilize the ODG medical/clinical protocol criteria, which are web-based, and are utilized and accessed by medical/nursing personnel.

T.C.A. Section 56-6-705 (9):

In compliance with T.C.A. Section 56-6-705 (9), in the event that nationally recognized standards for a specific treatment protocol do not exist to satisfy the requirements of subdivision (a)(2)(B)(i), Hoover will ensure that all adverse determinations related to the specific treatment protocol are made by a physician or psychologist. A physician will possess a valid license to practice medicine and be board certified or board eligible, or trained in the similar specialty as the health care provider who typically manages the medical condition or disease, or provides the health care service. A psychologist shall possess a valid license or certificate and shall be board certified or board eligible, or trained in the similar specialty as the health care provider who typically manages the medical condition or disease, or provides the health care service;

For information regarding compliance with T.C.A. Section 56-6-705 (a) 11, please see **EXHIBIT 8** – Outpatient Mental Health and Chemical Dependency Care.

ODG Formulary

The Bureau of Workers' Compensation has adopted the Work Loss Data Institute ODG® Drug Formulary as the Drug Formulary for use in the workers' compensation system. This allows for the review of certain medications prescribed to patients under workers' compensation.

- The Formulary identifies some medications within certain classes to require approval prior to dispensing. These medications are listed as a status "N" in the formulary.

- Medication listed as status "Y" or medications not listed may be dispensed without prior approval but may be subject to later review under certain circumstances.

Under existing rules, denials based upon a question of medical necessity require utilization review, and denials may only be made by a physician.

Review Process:

After review of the appropriate ODG medical/clinical protocol criteria**,** the nurse reviewer will choose one of 3 actions to complete the review:

1. Within 7 business days, notification of the approval of the UR request will be provided utilizing **EXHIBIT 3** – ("UR APPROVAL"). The injured worker, their legal representative (if applicable) and the requesting provider will be sent the "UR APPROVAL" notification.

T.C.A. Section 56-6-705 (4):

2. If Hoover requires additional information from an enrollee, a provider, or healthcare facility to make a determination on a request for prior authorization, then, no later than five (5) business days after receipt of the request, Hoover will notify:

   (A) The enrollee in writing, or through email or respective electronic portals, of the additional information needed to make the determination; and

(B) The provider or healthcare facility through email or respective electronic portals of the additional information needed to make the determination.

A notification, see **EXHIBIT 4** will be sent to the provider, notifying them of the need for more information.

3. Within 7 business days, If the UR reviewer has adequate information and opines that the requested services are not within the ODG guidelines, the request will be sent to a "like specialty physician, licensed in the state of TN" for further review. The Utilization Review Physician will either approve or deny the request. Recommended treatment can be denied only by a Utilization Review Physician who is of the same or similar specialty and licensed in the state of Tennessee. Denials must be accompanied by a utilization review report that gives the reasons for denial and the name and credentials of the utilization review physician. If approved, the "UR APPROVAL" (**EXHIBIT 1)** will be sent to all parties. If the services are denied, **EXHIBIT 5 (**"UR DENIAL") will be sent, in addition to a "pre-filled C-35A" form (**EXHIBIT 2** – C-35A – Notice of Appeal of Rights for a Utilization Review Denial), in addition to the reviewing physician's determination report of denial.

    a. The utilization review organization physician's determination report shall contain a list of all medical information reviewed, the assessment of those records, the basis of the determination in accordance with the Bureau's adopted treatment guidelines, and the name and credentials of the utilization review physician. This information is sent to all parties.

    b. The utilization review communication to the authorized treating physician shall separately contain the information necessary for a peer-to-peer telephonic conference, or instructions on accessing an electronic portal for secure electronic communication between the utilization review physician and the authorized treating physician. This information shall be sent to the authorized treating physician and copied to the employer as defined in these rules.

    c. The utilization review determination report shall include an attestation statement and the signature of the utilization review physician, documenting that the physician has personally reviewed the list of medical information reviewed and made the determination. It shall include the utilization review physician's Tennessee license number, board certification, information and any other appropriate credential that supports the qualification of the physician. The utilization review organization shall also include the name, address, and appropriate contact number or email address of the utilization review physician making a denial determination.

d. The Appeal Form shall also identify the state file number associated with the claim for which treatment is being recommended, if any, and shall identify the utilization review organization's number issued by the Bureau.

Appealing Denied Treatment:

Once the treating physician and the injured worker receive the denial and the C-35-A form and all the supporting documentation as above, an appeal can be made to:
A) the insurer or B) the TN Bureau of Workers' Compensation. (BWC).

The IW, treating physician or attorney has 30 calendar days from receipt of the denial to appeal the determination to the TN BWC. If appealed to the BWC, the Bureau's Medical Director is to make a determination. The Medical Director will approve, modify or deny the treatment and this decision is final for administrative purposes. The fee charged by the Bureau is paid by the insurer.

When the adjuster receives notification of an appeal being filed with the Bureau, the adjuster shall send to the Bureau, within (5) five business days, the same records as sent to the utilization review organization, including the medical records for the past twelve (12) months, the complete and current Form C35-A and the utilization review organization determination report, including the utilization review physician's report containing the medical rationale for the denial. These shall be sent to the Bureau without duplicates or billing and fax records and in chronological order, one sided, containing the medical records, diagnostic studies, and medical correspondence for one calendar year before the date of the denial/modification determination. These record requirements may be met by sending the documents that were reorganized by the utilization review organization. The employer may be subject to sanctions and/or civil penalties.

The BWC has provided "Instructions for Appeal", attached as "**EXHIBIT 6 – Appeal Process**".

Utilization Review Closure:

Upon closure of the Utilization Review on a claim, Hoover utilization review personnel will complete Form C-36/C-37 (**EXHIBIT 7** - LB-0375 Tennessee Department of Labor and Workforce Development) and submit the form to the Tennessee Department of Labor and Workforce Development/Division of Workers' Compensation.

Hoover's Yearly Report to TN BWC:

Each year no later than March 1, utilization review organizations shall send the Bureau an annual report, as described below, for the preceding calendar year.

1) The total number of requested utilization review organization determinations by utilization review organizations as defined in these rules;

2) The results of the determinations categorized by denials, modifications, and approvals;
3) The names of all utilization review physicians used by the utilization review organization during the preceding year and the number of reviews each utilization review physician performed, and if subcontracted, a list of utilization review physicians used by the subcontractor; and
4) A record of all peer-to-peer conferences requested, the number of conferences completed, the results by number of upholds, modifications, and overturns of the completed conferences; the names of the utilization review organization physician(s) involved, and the number of conferences participated in by each UR physician.
5) Failure to timely submit and annual report for a calendar year shall subject a party to a penalty of not less than fifty dollars nor more than five thousand dollars per violation at the discretion of the Administrator.

Sanctions and civil penalties:

Use of utilization review by an employer, carrier, or utilization review organization in an excessive or punitive manner, included but not limited to unjustified, repetitive, or poorly-supported utilization review activity as determined by the Administrator, where there has been a documented pattern by the employer, carrier, or utilization review organization, including attempts to force closure or alteration in a claim status, shall subject such party to a penalty of not less than fifty dollars ($50.00) nor more than five thousand dollars ($5,000.00) per violation at the discretion of the Administrator.

Mediation:

Parties who are not satisfied with the appeal process may file for mediation. Reviewing the denial, understanding its reasoning and gathering information might result in agreement. If mediation is not successful, a judge may rule on whether the Attending Treating Provider's recommended treatment was appropriate. Further information or questions about mediation should be directed to the Tennessee Bureau of Workers' Compensation at 1-800-332-2667.

FORM C-35

EXHIBIT 1

TENNESSEE BUREAU OF WORKERS' COMPENSATION

220 French Landing Dr.
Nashville, Tennessee 37243-1002

UTILIZATION REVIEW NOTIFICATION

EMPLOYEE INFORMATION

State File # _____ Date of Injury_____Social Security #_____

Claimant _____

EMPLOYER INFORMATION

FEIN: _____ Employer: _____

Street:_____City:_____State:_____Zip:_____

INSURER INFORMATION

Insurer: _____

Insurer Address: _____

Insurer Claim #: _____ Policy Number: _____

UTILIZATION REVIEW INFORMATION

Utilization review has been instituted because of at least one of the following. Please check the applicable threshold(s).

_____ Outpatient case where the injury results in medical costs in excess of five thousand dollars (5,000)

_____ In-patient hospital admission

_____ Other, explain _____

_____

_____

Utilization Review Provider _____

TN Registration Number _____

Utilization Review Provider Address _____

_____

_____

Utilization Review Provider Phone # _____

Utilization Review Provider Contact Person _____

Date Utilization Review Initiated _____

Comments _____

_____

_____

FORM C-35

TENNESSEE BUREAU OF WORKERS' COMPENSATION
220 French Landing Dr.
Nashville, Tennessee 37243-1002

UTILIZATION REVIEW NOTIFICATION **EXHIBIT 1**

Please **submit** the
Utilization Review Notification Form, (C-35)
via the CM/UR **portal**:
https://cmur.app.tn.gov/cmur/

Paper copies will not be accepted.

Utilization Review Organizations registered with
the BWC
that have an active status
may access the CM/UR portal.

For additional information,
email **UR.ResearchData@tn.gov**.

FORM C-35A

EXHIBIT 2

Tennessee Bureau of Workers' Compensation
220 French Landing Drive, 1-B Nashville, TN 37243-1002
(800) 332-2667 | tn.gov/workerscomp

Notice of Appeal Rights for a Utilization Review Denial

Adjusters: For every UR denial, adjusters must pre-fill this form and send it with the Utilization Review Denial and Utilization Reviewer's Report to the employee, treating physician or other provider and any attorneys listed. Delays, incomplete or inaccurate information could result in a penalty referral.

Employee/Physician/Attorney: Receiving this pre-filled notice means the requested treatment was reviewed and denied or modified by the carrier's Utilization Review Organization and denied by the adjuster. You have the right to ask the Bureau of Workers' Compensation to review the denial or modification by submitting this form. Follow the instructions on page 3. If no appeal is desired, you may keep this for your records.

Employee

Name:
State File No.:
Injury Date:
Address:
City/State/Zip:
Phone:
Email:

Initial Utilization Review

UR Organization:
Date of UR Report:
UR State Registration No.:
Denied Treatment:

Carrier/TPA/Self-Insured

Carrier:
Adjuster Name:
Adjuster Email:
Phone:
Fax:
Claim No.:
Compliance Unit Email:
Supervisor Name:
Supervisor Email:

Authorized Treating Physician

Name:
Address:
City/State/Zip:
Phone:
Fax:
Email:
Office Contact Name:
Contact Email:

FORM C-35A

EXHIBIT 2

Employer

Company Name:

Address:

City/State/Zip:

Phone:

Fax:

Email:

Employee Attorney

(if applicable)

Name:

Firm Name

Address:

Address 2:

City/State/Zip:

Phone:

Fax:

Email:

Employer/Carrier Attorney

(if applicable)

Name:

Firm Name

Address:

Address 2:

City/State/Zip:

Phone:

Fax:

Email:

Submitter

Person Submitting This Form

Name:

Title:

Organization:

Phone, Fax, or Email:

Signature:

Instructions for Appealing **EXHIBIT 2**

To request a review, follow the instructions below and submit this signed form and the required documents to the Tennessee Bureau of Workers' Compensation within thirty (30) calendar days of receiving the Utilization Review Denial:

1. Complete and sign the "Submitter" section on page 2 of **this form**.
2. Attach the **Utilization Review Denial** and **Utilization Reviewer's Report** that were included with this document when it was provided to you.
3. Attach any **medical records** you have from the past twelve (12) months pertaining to this injury, including office visits, diagnostic reports, operative notes, physical therapy notes, and hospital visits.

Send via

Email: UR.appeals@tn.gov

Fax: (615) 253-5265

Mail: Tennessee
Bureau of Workers' Compensation
ATTN: Medical Director
220 French Landing Drive, 1B
Nashville, TN 37243-1002

30 Day Deadline

If the requested documents are not sent to the Bureau within thirty calendar days, you may lose your right to appeal.

Questions?

If you have any questions or need assistance in completing this form, call 1-800-332-2667 or 615-253-4397.

UR.appeals@tn.gov

HOOVER **Hoover Rehabilitation Services, Inc.**

EXHIBIT 3

UTILIZATION REVIEW APPROVAL

Date

CONFIDENTIAL

Authorization Letter to Patient, Provider, Facility:

Claimant:
SS#:
Claim No:
Diagnosis:
Authorized Treatment:

Dear Patient, Provider, Facility:

Please be advised that a Utilization Review was requested by Provider Name for Treatment Plan/Service Type/Procedure:
CPT Code:

This letter will confirm Approval on Date

Full authorization was given.

Sincerely,
Utilization Review Department

Nurse Case Coordinator

This review applies only to the authorization/approval of medical necessity under Tennessee Workers' Compensation Law. Payment for services is made by the insurer and is subject to Medical Cost Containment Rules.

Insurance Adjuster:

(claimant)

(treating provider)

(attorney, if applicable)

EXHIBIT 4

NON-CERTIFICATION/REQUEST FOR ADDITIONAL INFORMATION

Date

CONFIDENTIAL

Copies of letters to Patient, Provider, Facility and Insurance Company:

Claimant:
SS#:
Claim No:
Diagnosis:

Dear Patient, Provider, Facility or Insurance Company:

Please be advised that Utilization Review was requested by Provider Name for
Treatment Plan/Service Type/Procedure:
CPT Code(s):

No authorization was provided at this time, as additional information is required.
Reason:

Sincerely,
Utilization Review Department

Nurse Case Coordinator

CC: Insurance Adjuster:
(claimant)

(treating provider)

(attorney, if applicable)

HOOVER **Hoover Rehabilitation Services, Inc.**

EXHIBIT 5

UTILIZATION REVIEW DENIAL

Date

CONFIDENTIAL

Copies of letters to Patient, Provider, Facility:

Claimant:
SS#:
Claim No:
Diagnosis:

Dear Patient, Provider, Facility:

Please be advised that a Utilization Review was requested by Provider Name for:

Treatment Plan/Service Type/Procedure:
CPT Code:

No authorization was given. Treatment is denied by utilization review.

Comments:

Clinical rationale for this determination is attached with the report of the Utilization Reviewer. An Appeal of this determination may be submitted to the Tennessee Department of Labor & Workforce Development Bureau of Workers' Compensation by filing the enclosed C-35A Form and following directions for submission.

Sincerely,
Utilization Review Department

Enclosures: Report of Utilization Review Medical Practitioner
C-35A Appeal Form

Insurance Adjuster:

(claimant)

(treating provider)

(attorney, if applicable)

EXHIBIT 6

RECONSIDERATION/APPEAL PROCESS

1. When Hoover renders a determination of denial of medical necessity regarding an admission, hospital stay, treatment plan, diagnostic test, or other service, the following will occur:

    - The Attending Physician, Employee, and Employee Attorney (if involved) will be notified in writing by Hoover via a Utilization Review Denial Letter.

    - The Utilization Review Denial Letter, a Utilization Reviewer's Report, and a C-35A Form and instruction sheet will be sent to the attending provider, the employee and employee attorney (if involved).

2. **Submitting an Appeal:**

    - To file an Appeal with the Tennessee Bureau of Workers' Compensation, the Submitter section on page 2 of the C-35A must be completed and signed. The Utilization Review Denial and Utilization Reviewer's Report must also be attached to the C-35A Form. The submitter must also attach any medical records available from the past twelve (12) months pertaining to the involved injury, including office visits, diagnostic reports, operative notes, physical therapy notes, and hospital visits.

    - The C-35A Form and all requested documents reflected above must be sent via email, Fax, or mailed, as instructed in the Instructions for Appealing of this Form.

    - This Appeal Process must be completed within 30 calendar days and submitted to the Bureau, or you may lose your right to appeal.

3. **Mediation:** Patients who are not satisfied with the Appeal may file for mediation. Reviewing the Denial, understanding its reasoning, and gathering information might result in agreement. If mediation is not successful, a judge may rule on whether the Attending Provider treatment plan was appropriate. Further questions about the mediation process should be directed to the Tennessee Bureau of Workers' Compensation at 1-800-332-2667.

TENNESSEE BUREAU OF WORKERS' COMPENSATION

220 French Landing Dr.
Nashville, Tennessee 37243-1002

UTILIZATION REVIEW CLOSURE

EXHIBIT 7

EMPLOYEE INFORMATION

State File #_____ Date of Injury_____ Social Security # _____

Claimant _____ DOB_____ Sex _____

EMPLOYER INFORMATION

FEIN: _____ Employer: _____

Street: _____ City:_____ State:_____ Zip: _____

INSURER INFORMATION

Insurer: _____

Insurer Address:_____

Insurer Claim #:_____ Policy Number: _____

UTILIZATION REVIEW INFORMATION

Utilization Review Company _____ TN ID# _____

License Number

Healthcare Provider_____ MD/Chiro/DO _____

Treating Facility _____ City _____

Address _____

Summary of Actions Taken by the Utilization Review Provider (Indicate each type of review performed. List the amount of savings including zero when applicable. Complete the "no actions taken" field if there were no discrepancies. The actual cost and length of physical therapy and chiropractic services must be documented even if there are no savings).

A. ☐ **Pre-admission Review** Diagnosis Code_____._____._____CPT Code

Requested length of stay _____

Authorized length of stay _____

Actual length of stay _____ Date / / - / /

Identified discrepancy code _____

In-Patient Savings $_____

Comments _____

B. ☐ **Concurrent Review** Diagnosis Code_____._____.

Procedure	CPT Code	Identified Discrepancy Code	Cost
		TOTAL SAVINGS	$

Comments _____

FORM C-36/C-37

EXHIBIT 7

C. ☐ **Retrospective Review** Diagnosis Code_____._____.

Procedure	CPT Code	Identified Discrepancy Code	Cost
		TOTAL SAVINGS	$

Comments _____

D. ☐ **Chiropractic Services** Diagnosis Code_____._____.

Requested Service	Cost	Authorized Service	Identified Discrepancy Code	Savings
			TOTAL SAVINGS	$

Length of Treatment _____ (Number of Weeks)
Total Cost of Treatment $_____

Comments _____

E. ☐ **Physical Therapy** Diagnosis Code_____._____.

Procedure	CPT Code	Identified Discrepancy Code	Cost
		TOTAL SAVINGS	$

Length of Treatment _____ (Number of Weeks)
Total Cost of Treatment $_____

Comments _____

F. ☐ No actions were taken.

G. Cost of Utilization Review $_____

H. Reviewer's Name _____

EXHIBIT 7

TENNESSEE BUREAU OF WORKERS' COMPENSATION
220 French Landing Dr.
Nashville, Tennessee 37243-1002

UTILIZATION REVIEW CLOSURE

Please **submit** the
Utilization Review Closure Form, (C-36/C-37)
via the CM/UR **Portal**:
https://cmur.app.tn.gov/cmur/

Paper copies will not be accepted.

Utilization Review Organizations
registered with the BWC
that have an active status
may access the CM/UR portal.

For additional information,
email **UR.ResearchData@tn.gov**.

EXHIBIT 8

T.C.A. Section 56-6-705 (a) 11

Outpatient Mental Health and Chemical Dependency Care

(A) For outpatient mental health and chemical dependency care, the patient must register pursuant to the requirements of the policy or contract. After registration, the patient shall be approved for at least twelve (12) visits to a particular provider, except as otherwise provided in this section;

(B) Initial utilization review for such outpatient mental health or chemical dependency patients shall be limited to no more than a two (2) page form to be submitted via facsimile or internet and pursuant to state and federal privacy rules, security rules, and any final rules issued pursuant to the Health Insurance Portability and Accountability Act (HIPAA). After November 1, 2005, or sooner if required by HIPAA, the form shall be restricted to a single page. After November 1, 2005, the provider may no longer fax the form but is required to use the internet to submit necessary information if the utilization review agent so requires. In the event that the utilization review agent elects to restrict the submissions to the internet, provisions must be made to fax the information in the event of computer malfunction;

(C) After the initial utilization review, additional information or follow-up utilization review for outpatient mental health or chemical dependency patients shall be limited to no more than eighteen percent (18%) of the total number of outpatient mental health and chemical dependency patients' reviews performed by the utilization review agent for the previous calendar year adjusted for the difference of covered lives in this state for the present calendar year, or as otherwise required by the Utilization Review Accreditation Commission (URAC) or the National Committee for Quality Assurance (NCQA). The eighteen-percent limit shall not apply to utilization review applicable to at risk populations, patients seen more than two (2) visits a week and patients for which substance abuse is reported or suspected. Calls from reviews to providers for appointment follow-up calls or for the credentialing process shall also not be subject to the eighteen-percent limit;

(D) After utilization review as provided in this subdivision (a)(11), patients shall be authorized for at least twelve (12) additional visits or as otherwise recommended by the treatment plan;

(E) Nothing in this part shall be construed to require compliance with the final security and privacy rules of HIPAA prior to the compliance dates set by the secretary of health and human services; and

(F) Nothing in this part shall affect the policy or contract benefits nor shall it affect the Mental Health Parity Act, compiled in §§ 56-7-2601 and 56-7-2360.