

R612. Labor Commission, Industrial Accidents.

R612-300. Workers' Compensation Rules - Medical Care.

~~[R612-300-1. Whom May Attend Industrial Patients.~~

~~_____ A. The employer has first choice of physicians; but if the employer fails or refuses to provide medical attention, the employee has the choice of physicians.~~

~~_____ B. An employee of an employer with an approved medical program may procure the services of any qualified practitioner for emergency treatment if a physician employed in the program is not available for any reason.~~

~~R612-300-2. Injured Workers' Right to Privacy.~~

~~_____ A. No agent of the employer or the employer's insurance carrier shall be present during an injured worker's visit with a medical provider, unless agreed upon by the claimant.~~

~~_____ B. If an agent of the employer or the employer's insurance carrier is excluded from the medical visit, the medical provider and the injured worker shall meet with the agent at the conclusion of the visit so as to communicate regarding medical care and return to work issues.~~

~~R612-300-3. Changes of Doctors and Hospitals.~~

~~_____ A. It shall be the responsibility of the insurance carrier or self-insured employer to notify each claimant of the change of doctor rules. Those rules are as follows:~~

~~_____ 1. If a company doctor, designated facility or PPO is named, the employee must first treat with that designated provider. The insurance carrier or self-insured employer shall be responsible for payment for the initial visit, less any health insurance copays and subject to any health insurance reimbursement, if the employee was directed to and treated by the employer's or insurance carrier's designated provider, and liability for the claim is denied and if the treating physician provided treatment in good faith and provided the insurance carrier or self-insured employer a report necessary to make a determination of liability. Diagnostic studies beyond plain x-rays would need prior approval unless the claimed industrial injury or occupational illness required emergency diagnosis and treatment.~~

~~_____ 2. The employee may make one change of doctor without requesting the permission of the carrier, so long as the carrier is promptly notified of the change by the employee.~~

~~_____ (a) Physician referrals for treatment or consultation shall not be considered a change of doctor.~~

~~_____ (b) Changes from emergency room facilities to private physicians, unless the emergency room is named as the "company doctor", shall not be considered a change of doctor. However, once private physician care has begun, emergency room visits are prohibited except in cases of:~~

~~_____ (i) Private physician referral, or~~

~~_____ (ii) Threat to life.~~

~~_____ 3. Regardless of prior changes, a change of doctor shall be automatically approved if the treating physician fails or refuses to rate permanent partial impairment.~~

~~_____ B. Any changes beyond those listed above made without the permission of the carrier/self-insurer may be at the employee's own expense if:~~

~~1. The employee has received notification of rules, or~~

~~2. A denial of request is made.~~

~~C. An injured employee who knowingly continues care after denial of liability by the carrier may be individually responsible for payment. It shall be the burden of the carrier to prove that the patient was aware of the denial.~~

~~D. It shall be the responsibility of the employee to make the proper filings with the division when changing locale and doctor. Those forms can be obtained from the division.~~

~~E. Except in special cases where simultaneous attendance by two or more medical care practitioners has been approved by the carrier/employer or the division, or specialized services are being provided the employee by another physician under the supervision and/or by the direct referral of the treating physician, the injured employee may be attended by only one practitioner and fees will not be paid to two practitioners for similar care during the same period of time.~~

~~F. The Director of the Division of Industrial Accidents may authorize an injured worker to be examined by another physician for the purpose of obtaining a further medical examination or evaluation pertaining to the medical issues involved, and to obtain a report addressing these medical issues in all cases where:~~

~~1. The treating physician has failed or refused to give an impairment rating, and/or~~

~~2. A substantial injustice may occur without such further evaluation.~~

~~G. The Commission has jurisdiction to decide liability for medical care allegedly related to an industrial accident.~~

~~R612-300-4. Filings.~~

~~A. Within one week following the initial examination of an industrial patient, nurse practitioners, physicians and chiropractors shall file "Form 123 - Physicians' Initial Report" with the carrier/self-insured employer, employee, and the division. This form is to be completed in as much detail as feasible. Special care should be used to make sure that the employee's account of how the accident occurred is completely and accurately reported. All questions are to be answered or marked "N/A" if not applicable in each particular instance. All addresses must include city, state, and zip code. If modified employment in #29 is marked "yes," the remarks in #29 must reflect the particular restrictions or limitations that apply, whether as to activity or time per day or both. Estimated time loss must also be given in #29. If "Findings of Examination" (#17) do not correctly reflect the coding used in billing, a reduction of payment may be made to reflect the proper coding. A physician, chiropractor, or nurse practitioner is to report every initial visit for which a bill is generated, including first aid, when a worker reports that an injury or illness is work related. All initial treatment, beyond first aid, that is provided by any health care provider other than a physician, chiropractor, or nurse practitioner must be countersigned by the supervising physician and reported on Form 123 to the Industrial Accidents Division and the insurance carrier or self-insured employer.~~

~~B.1. Any medical provider billing under the restorative services section of the Labor Commission's adopted Resource-Based Relative Value Scale (RBRVS) or the Medical Fee Guidelines shall file the~~

~~Restorative Services Authorization (RSA) form with the insurance carrier or self-insured employer (payor) and the division within ten days of the initial evaluation.~~

~~2. Upon receipt of the provider's RSA form, the payor has ten days to respond, either authorizing a specified number of visits or denying the request. No more than eight visits may be incurred during the authorization process.~~

~~3. After the initial RSA form is filed with the payor and the division, an updated RSA form must be filed for approval or denial at least every six visits until a fixed state of recovery has been achieved as evidenced by either subjective or objective findings. If the medical provider has filed the RSA form per this rule, the payor is responsible for payment, unless compensability is denied by the payor. In the event the payor denies the entire compensability of a claim, the payor shall so notify the claimant, provider, and the division, after which the provider may then bill the claimant.~~

~~4. Any denial of payment for treatment must be based on a written medical opinion or medical information. The denial notification shall include a copy of the written medical opinion or information from which the denial was based. The payor is not liable for payment of treatment after the provider, claimant, and division have been notified in writing of the denial for authorization to pay for treatment. The claimant may then become responsible for payment.~~

~~5. Any dispute regarding authorization or denial for treatment will be determined from the date the division received the RSA form or notification of denial for payment of treatment.~~

~~6. The claimant may request a hearing before the Division of Adjudication to resolve compensability or treatment issues.~~

~~7. Subjective objective assessment plan/procedure (SOAP notes) or progress notes are to be sent to the payor in addition to the RSA form.~~

~~8. Any medical provider billing under the Restorative Services Section of the RBRVS or the Commission's Medical Fee Guidelines who fails to submit the required RSA form shall be limited to payment of up to eight visits for a compensable claim. The medical provider may not bill the patient or employer for any remaining balances.~~

~~C. S.O.A.P. notes or progress reports of each visit are to be sent to the payor by all medical practitioners substantiating the care given, the need for further treatment, the date of the next treatment, the progress of the patient, and the expected return-to-work date. These reports must be sent with each bill for the examination and treatment given to receive payment. S.O.A.P. notes are not to be sent to the division unless specifically requested.~~

~~D. "Form 110 - Release to Return to Work" must be mailed by either the medical practitioner or carrier/employer to the employee and the division within five calendar days of release.~~

~~E. The carrier/employer may request medical reports in addition to regular progress reports. A charge may be made for such additional reports, which charge should accurately reflect the time and effort expended by the physician.~~

~~R612-300-5. Regulation of Medical Practitioner Fees.~~

~~Pursuant to Section 34A-2-407(9):~~

~~A. The Labor Commission of Utah:~~

~~1. Establishes and regulates fees and other charges for medical provider services as required for the treatment of a work-related injury or illness.~~

~~2. Adopts and by this reference incorporates the Optum Essential RBRVS, 2012 1st Quarter Emergency Update, 1761/RBRCU/1766R/RBRC12?RBRC/U1766R ("RBRVS"), as the method for calculating reimbursement and the 2012 American Medical Association Current Procedural Terminology ("CPT").~~

~~a. The non-facility total unit value will apply in calculating the reimbursement, except that procedures provided in a facility setting shall be reimbursed at the facility total unit value and the facility may bill a separate facility charge.~~

~~b. The CPT and RBRVS, are subject to the Utah Labor Commission's Medical Fee Guidelines and the following Labor Commission conversion factors for medical care rendered for a work-related injury or illness, effective December 1, 2012: (Conversion Rates below EFFECTIVE December 1, 2012, to be used with the RBRVS procedural Unit value as per specialty.)~~

~~Anesthesiology \$41.00 (1 unit per 15 minutes of anesthesia);~~

~~Medicine, E and M \$46.00;~~

~~Evaluation and Management codes 99201 — 99204 and 99211 — 99214 \$46.00;~~

~~Pathology and Laboratory \$52.00;~~

~~Radiology \$53.00;~~

~~Restorative Services \$46.00;~~

~~Surgery \$37.00;~~

~~All 20000 codes, codes 49505 thru 49525 and all 60000 codes of the CPT-4 coding guidelines \$58.00.~~

~~3. Adopts and incorporates by this reference the Utah Labor Commission's 2013 Medical Fee Guidelines, effective December 1, 2012. The Utah Medical Fee Guidelines can be obtained from the division for a fee sufficient to recover costs of development, printing, and mailing or can be downloaded at the Labor Commission's website.~~

~~4. Decides appropriate billing procedure codes when disputes arise between the medical practitioner and the employer or its insurance carrier. In no instance will the medical practitioner bill both the employer and the insurance carrier.~~

~~B. Employees cannot be billed for treatment of their work-related injuries or illnesses.~~

~~C. Discounting from the fees established by the Labor Commission is allowed only through specific contracts between a medical provider and a payor for treatment of work-related injury or illness.~~

~~D. Restocking fee 15%. Rule R612-2-16 covers the restocking fee.~~

~~E. Dental fees are not published. Rule R612-2-18 covers dental injuries.~~

~~F. Ambulance fees are not published. Rule R612-2-19 covers ambulance charges.~~

~~G. For procedures not covered by other provisions of this rule, medical providers have three options.~~

~~1. Medical providers may request preauthorization for a procedure from the insurance carrier.~~

~~2. Medical providers may present evidence to Medical Fee Committee for incorporating a procedure into the Commission's fee~~

~~schedule. However, such incorporation will have prospective effect only.~~

~~3. Medical providers may apply for hearing before the Commission's Adjudication Division pursuant to Subsection 34A-2-801(1)(c) to establish a reasonable fee for the procedure.~~

~~R612-300-6. Method of Rating.~~

~~A. For rating all impairments, which are not expressly listed in Section 34A-2-412, the Commission incorporates by reference "Utah's 2006 Impairment Guides" as published by the Commission for all injuries rated on or after July 11, 2006. For those conditions not found in "Utah's 2006 Impairment Guides," the American Medical Association's "Guides to the Evaluation of Permanent Impairment, Fifth Edition" are to be used.~~

~~R612-300-7. Adjusting Resource-Based Relative Value Scale (RBRVS) Codes.~~

~~A. When adjusting any medical provider's bill who has billed per the Commission's adopted RBRVS the adjusting entity shall provide one or more of the following explanations as applies to the down coding when payment is made to the medical provider:~~

~~1. Code 99202, 99203, 99204 or 99205 the submitted documentation for a new patient did not meet the three key components lacking in the level of history for the code billed.~~

~~2. Code 99202, 99203, 99204 or 99205 the submitted documentation for a new patient did not meet the three key components lacking in the level of examination for the code billed.~~

~~3. Code 99202, 99203, 99204 or 99205 the submitted documentation for a new patient did not meet the three key components lacking in the level of medical decision making for the code billed.~~

~~4. Code 99202, 99203, 99204, or 99205 the submitted documentation for a new patient did not meet the three key components lacking in the level of history and exam for the code billed.~~

~~5. Code 99213, 99214 or 99215 the submitted documentation for an established patient did not meet the two key components lacking in the level of history and exam that the code billed.~~

~~6. Code 99213, 99214 or 99215 the submitted documentation for an established patient did not meet the two key components lacking in the level of history and medical decision making for the code billed.~~

~~7. Code 99213, 99214 or 99215 the submitted documentation for the established patient did not meet the two key components lacking in the level of exam and medical decision making for the code billed.~~

~~B. The above explanations may be abbreviated, with a legend provided, to accommodate the space of computerized messages.~~

~~R612-300-8. Fees in Cases Requiring Unusual Treatment.~~

~~The RBRVS scheduled fees are maximum fees except that fees higher than RBRVS scheduled may be authorized by the Commission when extraordinary difficulties encountered by the physician justify increased charges and are documented by written reports.~~

~~R612-300-9. Hospital or Surgery Pre-Authorization.~~

~~Any ambulatory surgery or inpatient hospitalization other than a life or limb threatening admission, allegedly related to an~~

~~industrial injury or occupational disease, shall require pre-authorization by the employer/insurance carrier. Within two working days of a telephone request for pre-authorization, the employer/carrier shall notify the physician and employee of approval or denial of the surgery or hospitalization, or that a medical examination or review is going to be obtained. The medical examination/review must be conducted without undue delay which in most circumstances would be considered less than thirty days. If the request for pre-authorization is made in writing, the employer/carrier shall have four days from receipt of the request to notify the physician and employee. If the employee chooses to be hospitalized and/or to have the surgery prior to such pre-authorization or medical examination/review, the employee may be personally responsible for the bills incurred and may not be reimbursed for the time lost unless a determination is made in his/her favor.~~

~~R612-300-10. One Fee Only to be Paid in global Fee Cases.~~

~~— In a global fee case which is transferred from one doctor to another doctor, one fee only will be paid, apportioned at the discretion of the Commission. Adequate remuneration shall also be paid to the medical practitioner who renders first aid treatment where the circumstances of the case require such treatment.~~

~~R612-300-11. Surgical Assistants' Fees.~~

~~— Fees, in accordance with the Commission's adopted Resource-Based Relative Value Scale (RBRVS), in addition to the global fee for surgical services, will be paid surgical assistants only when specifically authorized by the employer or insurance carrier involved, or in hospitals where interns and residents are not available and the complexity of the surgery makes a surgical assistant necessary.~~

~~R612-300-12. Separate Bills.~~

~~— Separate bills must be presented by each surgeon, assistant, anesthetist, consultant, hospital, special nurse, or other medical practitioner within 30 days of treatment on a HCFA 1500 billing form so that payment can be made to the medical practitioner who rendered the service. All bills must contain the federal ID number of the person submitting the bill.~~

~~R612-300-13. Hospital Fees Separate.~~

~~— Fees covering hospital care shall be separate from those for professional services and shall not extend beyond the actual necessary hospital care. When it becomes evident that the patient needs no further hospital treatment, he/she must be discharged. All billings must be submitted on a UB92 form and be properly itemized and coded and shall include all appropriate documentation to support the billing. There shall not be a separate fee charged for the necessary documentation in billing for payment of hospital services. The documentation of hospital services shall include at a minimum the discharge summary. The insurance carrier may request further documentation if needed in order to determine liability for the bill.~~

~~R612-300-14. Charges for Ordinary Supplies, Materials, or Drugs.~~

~~— Fees covering ordinary dressing materials or drugs used in~~

~~treatment shall not be charged separately but shall be included in the amount allowed for office dressings or treatment.~~

~~**R612-300-15. Charges for Special or Unusual Supplies, Materials, or Drugs.**~~

~~—— A. Charges for special or unusual supplies, materials, or drugs not included as a normal and usual part of the service or procedure shall, upon receipt of an itemized and coded billing, be paid at cost plus 15% restocking fees.~~

~~—— B. For purposes of part A above, the amount to be paid shall be calculated as follows:~~

~~—— 1. Applicable shipping charges shall be added to the purchase price of the product;~~

~~—— 2. The 15% restocking fee shall then be added to the amount determined in sub part 1;~~

~~—— 3. The amount of taxes paid on the purchase of the supplies, materials, or drugs shall then be added to the amount determined in sub part 2, which sum shall constitute the total amount to be paid.~~

~~**R612-300-16. Fees for Unscheduled Procedures.**~~

~~—— Fees for medical or surgical procedures not appearing in the Commission's adopted RBRVS current fee schedule are subject to the Commission's approval and should be submitted to the Commission when the physician and employer or insurance carrier do not agree on the value of the service. Such fees shall be in proportion as nearly as practicable to fees for similar services appearing in the RBRVS.~~

~~**R612-300-17. Ambulance Charges.**~~

~~—— Ambulance charges must not exceed the rates adopted by the State Emergency Medical Service Commission for similar services.~~

~~**R612-300-18. Dental Injuries.**~~

~~—— A. This rule establishes procedures to obtain dental care for work-related dental injuries and sets fees for such dental care.~~

~~—— B. Initial Treatment.~~

~~—— 1. If an employer maintains a medical staff or designates a company doctor, an injured worker seeking dental treatment for work-related injuries shall report to such medical staff or doctor and follow their instructions.~~

~~—— 2. If an employer does not maintain a medical staff or designate a company doctor, or if such staff or doctor are not available, an injured worker may consult a dentist to obtain immediate care dental for injuries caused by a work-related accident. The insurer shall pay the dentist providing this initial treatment at 70% of UCR for the services rendered.~~

~~—— C. Subsequent care by initial treatment provider.~~

~~—— 1. If additional treatment is necessary, the dentist who provided initial treatment may submit to the insurer a request for authorization to continue treatment. The transmission date of the request must be verifiable. The request itself must include a description of the injury, the additional treatment required, and the cost of the additional treatment. If the dentist proceeds with treatment without authorization, the dentist must accept 70% of UCR as payment in full and may not charge any additional sum to the injured worker.~~

~~2. The insurer shall respond to the request for authorization within 10 working days of the request's transmission. This 10-day period can be extended only with written approval of the Industrial Accidents Division. If the insurer does not respond to the dentist's request for authorization within 10 working days, the insurer shall pay the cost of treatment as contained in the request for authorization.~~

~~3. If the insurer approves the proposed treatment, the insurer shall send written authorization to the dentist and injured worker. This authorization shall include the anticipated payment amount.~~

~~4. On receipt of the insurer's written authorization, and if the dentist accepts the payment provisions therein, the dentist may proceed to provide the approved services. The dentist must accept the amount to be paid by the insurer as full payment for those services and may not bill the injured worker for any additional amount.~~

~~D. Subsequent care by other providers.~~

~~1. If the dentist who provided initial treatment does not agree to the payment offered by the insurer, the insurer shall within 20 calendar days direct the injured worker to a dentist located within a reasonable travel distance who will accept the insurer's payment offer.~~

~~2. If the insurer cannot locate another dentist to provide the necessary services, the insurer shall attempt to negotiate a satisfactory reimbursement with the dentist who provided initial treatment. The negotiated reimbursement may not include any balance billing to the claimant.~~

~~3. If the insurer is successful in arranging treatment with another dentist, the insurer shall notify the injured worker.~~

~~4. If, after having received notice that the insurer has arranged the services of another dentist, the injured worker chooses to obtain treatment from a different dentist, the insurer shall only be responsible for payment at 70% of UCR. Under the circumstances of this subsection (4), the treating dentist may bill the injured worker for the difference between the dentist's charges and the amount paid by the insurer.~~

~~E. Payment or treatment disputes that cannot be resolved by the parties may be submitted to the Labor Commission's Adjudication Division for decision, pursuant to the Adjudication Division's established forms and procedures.~~

~~R612-300-19. HIV, Hepatitis B and C Testing and Reporting for Emergency Medical Service Providers.~~

~~A. Authority - The HIV, Hepatitis B and C Testing and Reporting for Emergency Medical Services Providers rule is established under the authority of U.C.A. Section 78B-8-404.~~

~~B. Purpose - To establish procedures pursuant to U.C.A. Section 78B-8-401 for source patient testing and reporting following a significant exposure of an emergency medical services provider.~~

~~C. Definitions~~

~~1. Department means the Utah Labor Commission.~~

~~2. Contact means designated person(s) within the emergency medical services agency or the employer of the emergency medical services provider.~~

~~3. Disease means Human Immunodeficiency Virus, acute or chronic Hepatitis B or Hepatitis C infections.~~

~~4. Emergency medical services provider means Emergency Medical personnel as defined in Section 26-8a-102, a public safety officer, local fire department personnel, or personnel employed by the Department of Corrections or by a county jail, who provide prehospital Emergency medical care for an emergency medical services agency either as an employee or a volunteer.~~

~~5. Emergency medical services (EMS) agency means an agency, entity, or organization that employs or utilizes emergency medical services providers as defined in (4) as employees or volunteers.~~

~~6. Source Patient means any individual cared for by a prehospital emergency medical services provider, including but not limited to victims of accidents or injury, deceased persons, and prisoners or persons in the custody of the Department of Corrections.~~

~~7. Receiving facility means a hospital, health care or other facility where the patient is delivered by the emergency medical services provider for care.~~

~~8. "Significant Exposure" and "Significantly Exposed" mean:~~

~~a. exposure of the body of one person to the blood or body fluids visibly contaminated by blood of another person by:~~

~~1. percutaneous injury, including a needle stick or cut with a sharp object or instrument; or~~

~~2. contact with an open wound, mucous membrane, or nonintact skin because of a cut, abrasion, dermatitis, or other damage; or~~

~~b. exposure that occurs by any other method of transmission defined by the Department of Health as a significant exposure.~~

~~D. Emergency Medical Services Provider Responsibility.~~

~~1. The EMS provider shall document and report all significant exposures to the receiving facility and contact as defined in (C) (2).~~

~~2. The reporting process is as follows:~~

~~a. The exposed EMS provider shall complete the Exposure Report Form (ERF) at the time the patient is delivered to the receiving facility and provide a copy to the person at the receiving facility authorized by the facility to receive the form. In the event the exposed EMS provider does not accompany the source patient to the receiving facility, he/she may report the exposure incident, with information requested on the ERF, by telephone to a person authorized by the facility to receive the form. In this event, the exposed EMS provider shall nevertheless submit a written copy of the ERF within three days to an authorized person of the receiving facility.~~

~~b. The exposed EMS provider shall, within three days of the incident, submit a copy of the ERF to the contact as defined in (C) (2).~~

~~E. Receiving Facility Responsibility:~~

~~1. The receiving facility shall establish a system to receive ERFs as well as telephoned reports from exposed EMS providers on a 24-hour per day basis. The facility shall also have available or on call, trained pre-test counselors for the purpose of obtaining consent and counseling of source patients when HIV testing has been requested by EMS providers. The receiving facility shall contact the source patient prior to release from the facility to provide the individual with counseling or, if unable to provide counseling, provide the source patient with phone numbers for a trained counselor to provide the counseling within 24 hours.~~

~~2. Upon notification of exposure, the receiving facility shall~~

~~request permission from the source patient to draw a blood sample for disease testing, as defined in (C) (3). In conjunction with this request, the source patient must be advised of his/her right to refuse testing and be advised that if he/she refuses to be tested that fact will be forwarded to the EMS agency or employer of EMS provider. The source patient shall also be advised that if he/she refuses to be tested, the EMS agency or provider may seek a court order to compel the source patient to submit to a blood draw for the disease testing.~~

~~Testing is authorized only when the source patient, his/her next of kin or legal guardian consents to testing, with the exception that consent is not required from an individual who has been convicted of a crime and is in the custody or under the jurisdiction of the Department of Corrections, or if the source patient is dead. If consent is denied, the receiving facility shall complete the ERF and send it to the EMS agency or employer of the EMS provider. If consent is received, the receiving facility shall draw a sample of the source patient's blood and send it, along with the ERF, to a qualified laboratory for testing.~~

~~3. The laboratory that the receiving facility has sent source patient's blood draw to shall send the disease test results, by Case ID number, to the EMS agency or employer of the EMS provider.~~

~~F. EMS Agency/Employer Responsibility:~~

~~1. The EMS agency/employer, upon receipt of the disease tests, from the receiving facility laboratory, shall immediately report the result, by case number, not name, to the exposed EMS provider.~~

~~2. The EMS agency/employer, upon the receipt of refusal of testing by the source, shall report that refusal to the EMS provider.~~

~~3. The agency/employer or its insurance carrier shall pay for the EMS provider and the source patient testing for the covered diseases per the Labor Commission fee schedule.~~

~~4. The EMS agency/employer shall maintain the records of any disease exposures contained in this rule per the OSHA Blood Borne Pathogen standards.~~

~~R612-300-20. Travel Allowance and Per Diem.~~

~~A. An employee who, based upon his/her physician's advice, requires hospital, medical, surgical, or consultant services for injuries arising out of and in the course of employment and who is authorized by the self-insurer, the carrier, or the Commission to obtain such services from a physician and/or hospital shall be entitled to:~~

~~1. Subsistence expenses of \$6 per day for breakfast, \$9 per day for lunch, \$15 per day for dinner, and actual lodging expenses as per the state of Utah's in-state travel policy provided:~~

~~(a) The employee travels to a community other than his/her own place of residence and the distance from said community and the employee's home prohibits return by 10:00 p.m., and~~

~~(b) The absence from home is necessary at the normal hour for the meal billed.~~

~~2. Reasonable travel expenses regardless of distance that are consistent with the state of Utah's travel reimbursement rates, or actual reasonable costs of practical transportation modes above the state's travel reimbursement rates as may be required due to the nature of the disability.~~

~~B. This rule applies to all travel to and from medical care with~~

the following restrictions:

- ~~1. The carrier is not required to reimburse the injured employee more often than every three months, unless:
 - ~~(a) More than \$100 is involved, or~~
 - ~~(b) The case is about to be closed.~~~~
- ~~2. All travel must be by the most direct route and to the nearest location where adequate treatment is reasonably available.~~
- ~~3. Travel may not be required between the hours of 10:00 p.m. and 6:00 a.m., unless approved by the Commission.~~
- ~~4. Requests for travel reimbursement must be submitted to the carrier for payment within one year of the authorized medical care.~~
- ~~5. Travel allowance shall not include picking up prescriptions unless documentation is provided substantiating a claim that prescriptions cannot be obtained locally within the injured worker's community.~~
- ~~6. The Commission has jurisdiction to resolve all disputes.~~

~~R612-300-21. Interest for Medical Services.~~

~~A. All hospital and medical bills must be paid promptly on an accepted liability claim. All bills which have been submitted properly on an accepted liability claim are due and payable within 45 days of being billed unless the bill or a portion of the bill is in dispute. Any portion of the bill not in dispute is payable within 45 days of the billing.~~

~~B. Per Section 34A-2-420, any award for medical treatment made by the Commission shall include interest at 8% per annum from the date of billing for the medical service.~~

~~R612-300-22. Medical Records.~~

~~A. Workers' compensation insurers, employers and the Utah Labor Commission need access to health information of individuals who are injured on the job or who have a work-related illness in order to process or adjudicate claims, or to coordinate care under Utah's workers' compensation system. Generally, this health information is obtained from health care providers who treat these individuals and who may be covered by federal "HIPAA" privacy rules.~~

~~The HIPAA Privacy Rule specifically recognizes the legitimate need of the workers' compensation system to have access to individuals' health information to the extent authorized by State law. See 45 CFR 164.512(1). The Privacy Rule also recognizes the importance of permitting disclosures required by other laws. See 45 CFR 164.512(a). Therefore, disclosures permitted by this rule for workers' compensation purposes or otherwise required by this rule do not conflict with and are not prohibited by the HIPAA Privacy Rule.~~

~~B. A medical provider, without authorization from the injured workers, shall:~~

- ~~1. For purposes of substantiating a bill submitted for payment or filing required Labor Commission forms, such as the "Physician's Initial Report of Injury/Illness" or the "Restorative Services Authorization," disclose medical records necessary to substantiate the billing, including drug and alcohol testing, to:~~

- ~~a. An employer's workers' compensation insurance carrier or third party administrator;~~

- ~~b. A self-insured employer who administers its own workers'~~

~~compensation claims;~~

~~— c. The Uninsured Employers' Fund;~~

~~— d. The Employers' Reinsurance Fund; or~~

~~— e. The Labor Commission as required by Labor Commission rules.~~

~~— 2. Disclose medical records pertaining to treatment of an injured worker, who makes a claim for workers' compensation benefits, to another physician for specialized treatment, to a new treating physician chosen by the claimant, or for a consultation regarding the claimed work related injury or illness.~~

~~— C.1. Except as limited in C(3), a medical provider, whose medical records are relevant to a workers' compensation claim shall, upon receipt of a Labor Commission medical records release form, or an authorization form that conforms to HIPAA requirements, disclose his/her medical records to:~~

~~— a. An employer's insurance carrier or third party administrator;~~

~~— b. A self-insured employer who administers its own workers' compensation claims;~~

~~— c. An agent of an entity listed in B(1)(a through e), which includes, but is not limited to a case manager or reviewing physician;~~

~~— d. The Uninsured Employers Fund;~~

~~— e. The Employers' Reinsurance Fund;~~

~~— f. The Labor Commission;~~

~~— g. The injured worker;~~

~~— h. An injured workers' personal representative;~~

~~— i. An attorney representing any of the entities listed above in an industrial injury or occupational disease claim.~~

~~— 2. Medical records are relevant to a workers' compensation claim if:~~

~~— a. The records were created after the reported date of the accident or onset of the illness for which workers' compensation benefits have been claimed; or~~

~~— b. The records were created in the past ten years (15 years if permanent total disability is claimed) and;~~

~~— i. There is a specific reason to suspect that the medical condition existed prior to the reported date of the claimed work related injury or illness or~~

~~— ii. The claim is being adjudicated by the Labor Commission.~~

~~— 3. Medical records related to care provided by a psychiatrist, psychologist, obstetrician, or care related to the reproductive organs may not be disclosed by a medical provider unless a claim has been made for a mental condition, a condition related to the reproductive organs, or the claimant has signed a separate, specific release for these records.~~

~~— D. A medical provider, who has treated an injured worker for a work related injury or illness, shall disclose information to an injured workers' employer as to when and what restrictions an injured worker may return to work.~~

~~— E. Requests for medical records beyond what sections B, C, and D permit require a signed approval by the director, the medical director, a designated person(s) within the Industrial Accidents Division or an administrative law judge if the claim is being adjudicated.~~

~~— F. A party affected by the decision made by a person in section E may appeal that decision to the Adjudication Division of the Labor~~

~~Commission.~~

~~G. Upon receipt and within the scope of this rule, an injured worker shall provide those entities or person listed in C(1) the names, address, and dates of medical treatment (if known) of the medical providers who have provided medical care within the past 10 years (15 years for permanent total disability claim) except for those medical providers names in C(3). Labor Commission form number 307 "Medical Treatment Provider List" must be used for this purpose. Parties listed in C(1) of this rule must provide each medical provider identified on form 307 with a signed authorization for access to medical records. A copy of the signed authorization may be sent to the medical providers listed on form 307.~~

~~H. An injured worker may contest, for good reason, a request for medical records created prior to the reported date of the accident or illness for which the injured worker has made a claim for benefits by filing a complaint with the Labor Commission. Good reason is defined as the request has gone beyond the scope of this rule or sensitive medical information is contained in a particular medical record.~~

~~I.1. Any party obtaining medical records under authority of this rule may not disclose those medical records, without a valid authorization, except as required by law.~~

~~2. An employer may only use medical records obtained under the authority of this rule to:~~

~~a. Pay or adjudicate workers' compensation claims if the employer is self-insured;~~

~~b. To assess and facilitate an injured workers' return to work;~~

~~c. As otherwise authorized by the injured worker.~~

~~3. An employer obtaining medical records under authority of this rule must maintain the medical records separately from the employee's personnel file.~~

~~J. Any medical records obtained under the authority of this rule to make a determination regarding the acceptance of liability or for treatment of a condition related to a workers' compensation claim shall only be used for workers' compensation purposes and shall not be released, without a signed release by the injured worker or his/her personal representative, to any other party. An employer shall make decisions related only to the workers' compensation claim based on any medical information received under this rule.~~

~~K. When any medical provider provides copies of medical records, other than the records required when submitting a bill for payment or as required by the Labor commission rules, the following charges are presumed reasonable:~~

~~1. A search fee of \$15 payable in advance of the search;~~

~~2. Copies at \$.50 per page, including copies of microfilm, payable after the records have been prepared and~~

~~3. Actual costs of postage payable after the records have been prepared and sent. Actual cost of postage are deemed to be the cost of regular mail unless the requesting party has requested the delivery of the records by special mail or method.~~

~~4. The Labor Commission will release its records per the above charges to parties/entities with a signed and notarized release from the injured worker unless the information is classified and controlled under the Government Records Access and Management Act (GRAMA).~~

~~L. No fee shall be charged when the RBRVS or the Commission's~~

~~Medical Fee Guidelines require specific documentation for a procedure or when medical providers are required to report by statute or rule.~~

~~M. An injured worker or his/her personal representative may obtain one copy of each of the following records related to the industrial injury or occupational disease claim, at no cost, when the injured worker or his/her personal representative have signed a form by the Industrial Accidents Division to substantiate his/her industrial injury/illness claim;~~

- ~~1. History and physical;~~
- ~~2. Operative reports of surgery;~~
- ~~3. Hospital discharge summary;~~
- ~~4. Emergency room records;~~
- ~~5. Radiological reports;~~
- ~~6. Specialized test results; and~~
- ~~7. Physician SOAP notes, progress notes, or specialized reports.~~

~~(a) Alternatively, a summary of the patients records may be made available to the injured worker or his/her personal representative at the discretion of the physician.~~

~~R612-300-23. Insurance Carrier's Privilege to Examine.~~

~~The employer or the employer's insurance carrier or a self-insured employer shall have the privilege of medical examination of an injured employee at any reasonable time. A copy of the medical examination report shall be made available to the Commission at any time upon request of the Commission.~~

~~R612-300-24. Notice to Health Care Providers.~~

~~Any notice from a carrier denying further liability must be mailed to the Commission and the patient on the same day as it is mailed to the health care provider. Where it can be shown, in fact, that a medical care provider and the injured employee have received a denial of further care by the insurance carrier or self-insured employer, further treatment may be performed at the expense of the employee. Any future ratification of the denial by the Commission will not be considered a retroactive denial but will serve to uphold the force and effect of the previous denial notice.~~

~~R612-300-25. Review of Medical Payments.~~

~~A. Health care providers and payors are primarily responsible to resolve disputes over fees for medical services between themselves. However, in some cases it is necessary to submit such disputes to the Division for resolution. The Commission therefore establishes the following procedure for submission and review of fees for medical services.~~

- ~~1. The provider shall submit a bill for services rendered, with supporting documentation, to the payor within one year of the date of service;~~
- ~~2. The payor shall evaluate the bill according to the guidelines contained in the Commission's Medical Fee Guidelines and RBRVS and shall pay the provider the appropriate fee within 45 days as required by Rule R612-2-13.~~
- ~~3. If the provider believes that the payor has improperly computed the fee under the RBRVS, the provider or designee shall request the payor to re-evaluate the fee. The provider's request for~~

~~re-evaluation shall be in writing, shall describe the specific areas of disagreement and shall include all appropriate documentation. The provider shall submit all requests for re-evaluation to the payor within one year of the date of the original payment.~~

~~4. Within 30 days of receipt of the written request for re-evaluation, the payor shall either pay the additional fee due the provider or respond with a specific written explanation of the basis for its denial of additional fees. The payor shall maintain proof of transmittal of its response.~~

~~B. If the provider continues to disagree with the payor's determination of the appropriate fee, the provider shall submit the matter to the Division by filing with the Division a written explanation of the disagreement. The provider's explanation shall include copies of:~~

~~1. The provider's original bill and supporting documentation;~~

~~2. The payor's initial payment of that bill;~~

~~3. The provider's request for re-evaluation and supporting documentation; and~~

~~4. The payor's written explanation or its denial of additional fees.~~

~~C. The Division will evaluate the dispute according to the requirements of the Medical Fee Guidelines and RBRVS and, if necessary, by consulting with the provider, payor, or medical specialists. Within 45 days from the date the Division receives the provider's request, the Division will mail its determination to both parties.~~

~~D. Any party aggrieved by the Division's determination may file an application for hearing with the Division of Adjudication to obtain formal adjudication of the dispute.~~

~~E. A payor seeking reimbursement from a provider for overpayment of a bill shall submit a written request to the provider detailing the circumstances of the payment requested within one year of submission of the bill.~~

~~1. Providers should make appropriate reimbursements, or respond in writing detailing the reasons why repayment will not be made, within 90 days of receipt of a written request from a payor.~~

~~2. If a dispute as to reimbursement occurs, an aggrieved party may request resolution of the dispute by the Labor Commission.~~

~~R612-300-26. Utilization Review Standards.~~

~~A. As used in this subsection:~~

~~1. "Payor" means a workers' compensation insurance carrier, a self-insured employer, third-party administrator, uninsured employer or the Uninsured Employers' Fund, which is responsible for payment of the workers' compensation claim.~~

~~2. "Health Care Provider" means a provider of medical services, including an individual provider, a health-service plan, a health-care organization, or a preferred provider organization.~~

~~3. "Request for Authorization" means any request by a physician for assurance that appropriate payment will be made for a course of proposed medical treatment, including surgery or hospitalization, or any diagnostic studies beyond plain X-rays.~~

~~4. "Utilization Review," as authorized in Section 34A-2-111, is a process used to manage medical costs, improve patient care, and enhance decision-making. Utilization review includes, but is not~~

limited to, the review of requests for authorization to treat, and the review of bills, for the purpose of determining whether the medical services provided were or would be necessary, to treat the effects of the injury/illness. Utilization review does not include bill review for the purpose of determining whether the medical services rendered were accurately billed. Nor does it include any system, program, or activity in connection with making decisions concerning whether a person has sustained an injury or illness which is compensable under Section 34A-2 or 34A-3.

5. "Reasonable Attempt" is defined as at least two phone calls and a fax, or three phone calls, within five business days from date of the payor's receipt of the physician's request for review.

B. Any utilization review system shall establish an appeals process which utilizes a physician(s) for a final decision by the insurer, should an initial review decision be contested. The payor may establish levels of review that meet the following criteria:

1. Level I--Initial Request and Review. A payor may use medical or non-medical personnel to initially apply medically based criteria to a request for authorization for payment of a specific treatment. The treating physician must send all the necessary documentation for the payor to make a decision regarding the treatment recommended. The payor must then notify the physician within five business days of the request for authorization of payment for the treatment, by a method which provides certification of transmission of the document, of either an acceptance or a denial of the request. A denial for authorization of payment for a recommended treatment utilizing the Commission's form, Form 223, must be sent to the provider with the criteria used in making the determination to deny payment for the treatment. A copy of the denial must also be mailed to the claimant. Level I--Request and Review does not include authorization requests for services billed from the Restorative section of the Resource Based Relative Value Scale (RBRVS). Requests for authorization for restorative services are governed by rule R612-2-3(B).

2. Level II--Review. A physician, who has been denied authorization of payment for treatment, or has received no response within five business days from the request for authorization for payment at Level I review, may request a physician's review by sending the completed portion of the Commission form 223 to the payor. Such a request for review may be filed by any physician who has been denied authorization for payment for restorative services beyond the initial eight visits as authorized by Rule R612-2-3(B). The requesting physician must include the times and days that he/she is available to discuss the case with the reviewing physician, and must be reasonably available during normal business hours. The payor's physician representative must complete the review within five business days of the treating physician's request for review. Before the insurer's physician representative may issue a denial of an authorization for payment to treat, a reasonable effort must have made to contact the requesting treating physician to discuss the differing aspects of the case. Failure by the payor to respond within five business days, by a method which provides certification of transmission, to a denial for authorization for payment for treatment, shall constitute an authorization for payment of the treatment. The payor's denial to pay for the recommended treatment must be issued on Commission's form 223,

~~and the denial must be accompanied by the criteria that was used in making the decision to deny authorization, along with the name and speciality of the reviewing physician. The denial to authorize payment for treatment must then be sent to the physician, the claimant, and the Commission. The payor shall notify the Commission if an additional five days is needed in order to contact the treating physician or to review the case. An additional extension of time may be requested from the Commission to accommodate highly unusual circumstances or particularly difficult cases.~~

~~C. Upon receipt of denial of authorization for payment for medical treatment at Level II, the Commission will facilitate, upon the request of the claimant, the final disposition of the case. If the parties agree, the medical dispute may be resolved by the Commission through binding mediation or medical review. If there is not agreement among the parties, the Commission will resolve the dispute through formal adjudication. The payor shall be responsible for sending the claimant the Commission appeals information when the denial for authorization for payment for medical treatment is sent to the claimant.~~

~~D. If the medical treatment requested is not an emergency, and treatment is rendered by the physician after, receiving notice of the utilization standards encompassed in this rule, the following shall apply:~~

~~1. The Commission shall, if the disputed medical treatment is ultimately determined to be compensable as an expense necessary to treat the industrial injury or occupational disease, order that the physician be reimbursed at only 75% of the of the amount otherwise payable had appropriate authorization been timely obtained. The injured worker shall not be liable for any additional payment to the physician above the 75%.~~

~~2. Neither the worker's employer or its workers' compensation insurer shall be liable for any portion of the cost of disputed medical treatment, if that treatment is ultimately determined not to be compensable as an expense necessary to treat an industrial injury or occupational disease.~~

~~3. A worker may become liable for the cost of the disputed medical treatment, if that treatment is ultimately determined not to be compensable as an expense necessary to treat the industrial injury or occupational disease.~~

~~4. Except for any co-pays or deductibles under the worker's health insurance plan, the penalty provision in D(1) and D(3) shall not apply if the physician performs the medical treatment in question, having been preauthorized in writing to do the same by a health insurer or other non-worker's compensation insurance payor.~~

~~5. The penalty provisions in D(1) shall not apply to medical treatment rendered in emergency situations, which are defined as a threat to life or limb.~~

~~6. The Commission shall notify a physician, in writing, of reported violations of this rule. Repeated violations of this rule by a physician may result in a report from the Commission to the Department of Commerce, Division of Occupational/Professional Licensing.~~

~~R612-300-27. Commission Approval of Health Care Treatment Protocols.~~

~~_____ A. Authority. Pursuant to authority granted by Section 34A-2-111(2)(c)(i)(B)(VII) of the Utah Workers' Compensation Act, the Utah Labor Commission establishes the following standards and procedures for Commission approval of medical treatment and quality care guidelines.~~

~~_____ B. Standards:~~

~~_____ 1. Scientifically based: Section 34A-2-111(2)(c)(i)(B)(VII)(Aa) of the Act requires that guidelines be scientifically based. The Commission will consider a guideline to be "scientifically based" when it is supported by medical studies and/or research.~~

~~_____ 2. Peer reviewed: Section 34A-2-111(2)(c)(i)(B)(VII)(Bb) of the Act requires that guidelines be peer reviewed. The Commission will consider a guideline to be "peer reviewed" when the medical study's content, methodology, and results have been reviewed and approved prior to publication by an editorial board of qualified experts".~~

~~_____ 3. Other standards: Pursuant to its rulemaking authority under Section 34A-2-111(2)(c)(i)(B)(VII), the Utah Labor Commission establishes the following additional standards for medical treatment and quality care guidelines.~~

~~_____ a. The guidelines must be periodically updated and, subject to Commission discretion, may not be approved for use unless updated in whole or in part at least biannually;~~

~~_____ b. Guideline sources must be identified;~~

~~_____ c. The guidelines must be reasonably priced;~~

~~_____ d. The guidelines must be easily accessible in print and electronic versions.~~

~~_____ C. Procedure: Pursuant to Section 34A-2-111(2)(c)(i)(B)(VII) of the Utah Workers' Compensation Act, a party seeking Commission action to approve or disapprove a guideline shall file a petition for such action with the Labor Commission.]~~

R612-300-1. Purpose, Scope and Definitions.

A. Purpose and scope. Pursuant to authority granted the Utah Labor Commission under §34A-2-407(9) and §34A-2-407.5(1) of the Utah Workers' Compensation Act, these rules establish:

1. Reasonable fees for medical care necessary to treat workplace injuries;

2. Standards for disclosure of medical records;

3. Reporting requirements; and

4. Treatment protocols and quality care guidelines.

B. Definitions. The following definitions apply within Rule R612-300:

1. "Health care provider" is defined by §34A-2-111(1)(a) as "a person who furnishes treatment or care to persons who have suffered bodily injury" and includes hospitals, clinics, emergency care centers, physicians, nurses and nurse practitioners, physician's assistants, paramedics and emergency medical technicians.

2. "Injured worker" is an individual claiming workers' compensation medical benefits for a work-related injury or disease.

3. "Payor" is the entity responsible for payment of an injured worker's medical expenses';

4. "Physician" is defined by §34A-2-111(1)(b) to included any licensed podiatrist, physical therapist, physician, osteopath,

dentist or dental hygienist, physician's assistant, naturopath, acupuncturist, or advance practice registered nurse.

5. "Workplace injury" is an injury or disease compensable under either the Utah Workers' Compensation Act or the Utah Occupational Disease Act.

R612-300-2. Obtaining Medical Care for Injured Workers.

A. Right of payor to designate initial health care provider.

1. A Payor may adopt managed health care programs. Such programs may designate specific health care providers as "preferred providers" for providing initial medical care for injured workers.

2. A preferred provider program must allow an injured worker to select from two or more providers to obtain necessary medical care.

At the time a preferred provider program is established, the payor must notify employees of the requirements of the program.

3. If the requirement of subsection A.2. are met, an injured worker subject to a preferred provider program must seek initial medical care from a preferred provider unless:

a. No preferred provider is available;

b. The injured worker believes in good faith that his or her medical condition is not a workplace injury; or

c. Travel to a preferred provider is unduly burdensome.

4. If an injured worker who is subject to a preferred provider program fails to obtain initial medical care from a preferred provider, the payor's liability for the cost of such initial medical care is limited to the amount the payor would have paid a preferred provider.

The injured worker may be held personally liable for the remaining balance.

B. Liability for medical expense incurred at payor's direction.

If a payor directs an employee to obtain an initial medical assessment of a possible work injury, the payor is liable for the cost of such assessment.

1. A medical provider performing an initial assessment must obtain the payor's preauthorization for any diagnostic studies beyond plain x-rays.

C. Injured worker's right to select provider after initial medical care. After an injured worker has received initial care from a preferred provider, the employee may obtain subsequent medical care from a qualified provider of his or her choice. The payor is liable for the expense of such medical care.

1. An employee's right to select medical providers is subject to subsection D. of this rule, "Limitations to Injured Worker's Right to Change Physicians."

D. Limitations on injured worker's right to change physicians.

1. An injured worker may change health care providers one time without obtaining permission from the payor. The following circumstances DO NOT constitute a change of health care provider:

a. A treating physician's referral of the injured worker to another health care provider for treatment or consultation;

b. Transfer of treatment from an emergency room to a private physician, unless the emergency room was designated as the payor's preferred provider;

c. Necessary emergency treatment;

d. A change of physician necessitated by the treating physician's

failure or refusal to rate a permanent partial impairment.

2. The injured employee shall promptly report any change of provider to the payor.

3. After an injured worker has exercised his or her one-time right to change health care providers, the worker must request payor approval of any subsequent change of provider. If the payor denies or fails to respond to the request, the injured worker may request approval from the Director of the Division on Industrial Accidents. The Director will authorize a change of provider if necessary for the adequate medical treatment of the injured worker or for other reasonable cause.

4. An injured worker who changes health care providers without payor or Division approval may be held personally liable for the non-approved provider's fees.

E. Hospital or surgery pre-authorization. Except when immediate surgery or hospitalization is medically necessary on an emergency basis, surgery or hospitalization must be pre-authorized by the payor.

1. Within two working days of receipt of a request for authorization, the payor shall notify the physician and injured worker that the request is either approved or denied, or is undergoing medical review.

2. Any medical review of a pending request for authorization must be conducted promptly.

F. Notification required from injured employees leaving Utah. Section 34A-2-604 of the Workers' Compensation Act requires injured workers receiving medical care for a workplace injury to notify the Industrial Accidents Division before leaving the state or locality. Division forms 043 and Form 044 are to be used to provide such notice.

G. Injured worker's right to privacy. No agent of the payor may be present during an injured worker's medical care without the consent of the injured worker. However, if the payor's agent is excluded from a medical visit, the physician and the injured worker shall meet with the agent at the conclusion of the visit or at some other reasonable time so as to communicate regarding medical care and return-to-work issues.

H. Payor's right of medical examination. The payor may arrange for the medical examination of an injured worker at any reasonable time and place. A copy of the medical examination report shall be made available to the Commission upon request.

R612-300-3. Required Reports.

A. Form 123, Physician's Initial Report. Within one week after providing initial medical care to an injured worker, a health care provider shall complete "Form 123 - Physicians' Initial Report." The provider shall fully complete Form 123 according to its instructions. The provider shall then file Form 123 with the Division and payor.

1. Form 123 must be completed and filed for every initial visit for which a bill is generated, including first aid, when the worker reports that his or her medical condition is work related.

2. If initial medical care is provided by any health care provider other than a physician, Form 123 must be countersigned by the supervising physician.

B. Form 221, Restorative Services Authorization. Form 221, "Restorative Services Authorization Form" required by Rule 612-300-5. C. 7. shall be filed with both the payor and the Division.

C. Forms 043, Employee's Intent to Leave State, and Form 044, Attending Physician's Statement. These forms are to be submitted to the Division before an injured worker leaves Utah.

D. Form 110, Release to Return to Work. Form 110 shall be mailed by either the health care provider or payor to the injured worker and Division within five calendar days after the health care provider releases the injured worker to return to work.

R612-300-4. General Method For Computing Medical Fees.

A. Adoption of "CPT" and "RBRVS." The Labor Commission hereby adopts and by this reference incorporates:

1. "Optum 2013 Current Procedural Coding Expert, CPT codes with Medicare essentials enhanced for accuracy," ("CPT" hereafter); and

2. "Optum 2013 The Essential RBRVS, 2013 1st Quarter Emergency Update," designated as 1761/RBRCU/U1771R-RBRC13/RBRC/U1771R, ("RBRVS" hereafter).

B. Medical fees calculated according to CPT and RBRVS. Unless some other provision of these rules specifies a different method, the CPT and RBRVS are to be used in conjunction with the "conversion factors" established in subsection C. of this rule to calculate payments for medical care provided to injured workers.

C. Conversion Factors. Fees for medical care of injured workers shall be computed by determining the relative value unit ("RVU") assigned by the RBRVS to a CPT code and then multiplying that RVU by the following conversion factors for specific medical specialties:

1. Anesthesiology (1 unit per 15 minutes of anesthesia) \$50.00;

2. Medicine (Evaluation and Medicine Codes 99201 - 99204 and 99211) \$46.00;

3. Pathology and Laboratory \$52.00;

4. Radiology \$53.00;

5. Restorative Services \$46.00;

6. Surgery (all 20000 codes, codes 49505 thru 49525, and all 60000 codes) \$58.00;

7. Other Surgery \$37.00.

D. Fees for Medical care not addressed by CPT/RBRVS, or requiring unusual treatment.

1. The payor and medical provider may establish and agree to a reasonable fee for medical care of an injured worker if:

a. neither the CPT/RBRVS or any other provision of these rules address the medical care in question; or

b. application of CPT/RBRVS or other provisions of these rules would result in an inadequate fee due to extraordinary difficulty of treatment.

2. If the medical provider and payor cannot agree to a reasonable fee in such cases, the provider can request a hearing before the Commission's Adjudication Division to establish a reasonable fee.

R612-300-5. Fees for Specific Procedures.

A. Needle procedures: Trigger point injections are reported per muscle. Payment under CPT code 20553 for injections of up to

three muscles is the maximum allowed for any one treatment session, regardless of the number of muscles treated.

B. Radiology.

1. The cost of radioisotopes, gadolinium and comparable materials may be charged at the provider's cost plus 15%.

2. When x-rays are reviewed as part of an independent evaluation of the patient, a consultation, or other office visit, the review is included as a part of the basic service to the patient and may not be billed separately.

C. Restorative Services.

1. The following criteria must be met before payment is allowed for restorative services:

a. The patient's condition must have the potential for restoration of function;

b. The treatment must be prescribed by the treating physician;

c. The treatment must be specifically targeted to the patient's condition; and

d. The provider must be in constant attendance during the providing of treatment.

2. No payment is allowed for CPT codes 97024, diathermy; 97026, infrared therapy; 97028, ultraviolet therapy/cold laser therapy; 97005, athletic training evaluations; 97006, athletic training reevaluation.

3. All restorative services provided must be itemized even if not billed.

4. Medical providers billing under CPT codes 97001 through 97703 are limited to payment for a maximum of three procedures/units per visit, or six procedures if different sites are treated. Services billed under CPT codes 97545, 97546 and 97150 require preauthorization and are limited to 4 units per injury. The payer shall pay the three highest valued procedures for each treatment site for the visit.

5. Patient education is to be billed using CPT code 97535 rather than codes 98960 through 98962, and is limited to 4 units per injury claim.

6. The entire spine is considered to be a single body part or unit. For that reason, CPT codes 98941 through 98943 and 98926 through 98929 may not be used for billing purposes.

7. When a change in treatment or a new RSA is required, physicians and physical therapists may bill for one evaluation and up to 2 modalities/procedures. Without an evaluation, they may bill for up to 3 modalities/procedures. With prior authorization from the payor, physicians and physical therapists may make additional billing when justified by special circumstances.

8. Any medical provider billing for restorative services shall file the appropriate version of Form 221, "Restorative Services Authorization (RSA) form" with the payor and the Division within ten days of the initial evaluation. Subjective/objective/assessment/plan ("SOAP") notes are to be sent to the payor in addition to the RSA form. SOAP notes are not to be sent to the Division unless requested.

a. Upon receipt of the provider's RSA form and SOAP notes, the payor shall respond within ten days by authorizing a specified number of treatments or denying the request. No more than eight

treatments may be provided during this ten-day authorization period.

b. A payor may deny the requested treatments for the following reasons:

i. The injury or disease being treated is not work related;
or

ii. The payor has received written medical opinion or other medical information indicating the treatment is not necessary. A copy of such written opinion or information must be provided to the injured worker, the medical provider, and the Division.

c. In cases where approval is received for initial treatment, the provider shall submit updated RSA forms and SOAP notes to the payor for approval or denial at least every six treatments.

d. An injured worker or provider may request a hearing before the Division of Adjudication to resolve issues of compensability, necessity of treatment, and compliance with this subsection's time limits.

D. Functional Capacity Evaluations. The following functional capacity evaluations require payor preauthorization and are billed in 15 minute increments under CPT code 97750:

1. A limited functional capacity evaluation to determine an injured worker's dynamic maximal repetitive lifting, walking, standing and sitting tolerance. Billing for this type of evaluation is limited to a maximum of 45 minutes.

2. A full functional capacity evaluation to determine an injured worker's maximum and repetitive lifting, walking, standing, sitting, range of motion, predicted maximal oxygen uptake, as well as ability to stoop, bend, crawl or perform work in an overhead or bent position. In addition, this evaluation includes reliability and validity measures concerning the individual's performance. Billing for this type of evaluation is limited to a maximum of 2.5 hours.

3. A work capacity evaluation to determine an injured worker's capabilities based on the physical aspects of a specific job description. Billing for this type of evaluation is limited to a maximum of 2 hours.

4. A job analysis to determine the physical aspects of a particular job. Billing is not subject to a maximum time limit due to the variability of factors involved in the analysis.

E. Impairment Ratings and Insurance Medical Examinations.

1. Impairment Rating by Treating Physician. Treating physicians shall bill for preparation of impairment ratings under CPT code 99455, with 2.0 RVU assigned/30 minutes.

2. Impairment Rating by Non-Treating Physician. Non-treating physicians may bill for preparation of impairment ratings under CPT code 99456, with 2.65 RVU assigned/30 minutes.

3. Medical Evaluations Commissioned by Payors. The Labor Commission does not regulate fees for medical evaluations requested by payors.

F. Transcutaneous Electrical Nerve Simulators (TENS). No fee is allowed for TENS unless it is prescribed by a physician and supported by prior diagnostic testing showing the efficacy of TENS in control of the patient's chronic pain. TENS testing and training is limited to four (4) sessions and a 30-day trial period but may be extended with written documentation of medical necessity.

G. Electrophysiologic Testing. A physician who is legally

authorized by his or her medical practice act to diagnose injury or disease is entitled to the full fee for electrophysiologic testing. Physical therapists and physicians who are qualified to perform such testing but who are not legally authorized to diagnose injury or disease are entitled to payment of 75% of the full fee.

H. Dental Injuries.

1. Initial Treatment.

a. If an employer maintains a medical staff or designates a company doctor, an employee requiring treatment for a workplace dental injury shall report to such medical staff or doctor and follow their directions for obtaining the necessary dental treatment.

b. If an employer does not maintain a medical staff or designate a company doctor, or if such medical staff or doctor is unavailable, the injured worker may obtain the necessary dental care from a dentist of his or her choice. The payor shall pay the dentist at 70% of UCR for services rendered.

2. Subsequent treatment.

a. If additional dental care is necessary, the dentist who provided initial treatment may submit to the payor a request for authorization to continue treatment. The transmission date of the request must be verifiable. The request itself must include a description of the injury, the additional treatment required, and the fee to be charged for the additional treatment.

i. The payor shall respond to the request for authorization within 10 working days of the request's transmission. This 10-day period can be extended with written approval of the Director of the Industrial Accidents Division.

ii. If the payor does not respond to the dentist's request for authorization within 10 working days, the dentist may proceed with treatment and the payor shall pay the cost of treatment as contained in the request for authorization.

iii. If the payor approves the proposed treatment, the payor shall send written authorization to the dentist and injured worker. This authorization shall include the amount the payor agrees to pay for the treatment. If the dentist accepts the payor's payment offer, the dentist may proceed to provide the approved services and shall be paid the agreed upon amount.

iv. If the dentist proceeds with treatment without authorization, the dentist's fee is limited to 70% of UCR.

b. If the dentist who provided initial treatment is unwilling to provide subsequent treatment under the terms outlined in subsection 2.a., above, the payor shall within 20 calendar days direct the injured worker to a dentist located within a reasonable travel distance who will accept the payor's payment offer.

i. If, after receiving notice that the payor has arranged for the services of a dentist, the injured worker chooses to obtain treatment from a different dentist, the payor shall only be liable for payment at 70% of UCR. The treating dentist may bill the injured worker for the difference between the dentist's charges and the amount paid by the insurer.

c. If the payor is unable to locate another dentist to provide the necessary services, the payor shall attempt to negotiate a satisfactory reimbursement with the dentist who provided initial treatment.

J. Procedures for which no fee is allowed. Due to a lack of evidence of medical efficacy, no payment is authorized for the following:

1. Muscle Testing, CPT codes 95832 through 95857;
2. Computer based Motion Analysis, CPT codes 96000 through 96004;
3. Athletic Training Evaluation, CPT codes 97005 and 97006;
4. Acupuncture, CPT codes 97810 through 97814;
5. Analysis of Data, now BR, CPT code 99090;
6. Patient Education, CPT codes 98960 through 98962;
7. Educational supplies, CPT code 99071; or
8. Thermograms, artificial discs, percutaneous diskectomies, endoscopic diskectomies, IDEPT, platelet rich plasma injections, thermo-rhizotomies and other heat or chemical treatments for discs.

R612-300-6. Limitations on Fees for Specific Medical Providers and Non-Physicians.

A. Physician Assistants, Nurse Practitioners, Medical Social Workers, Nurse Anesthetists, and Physical Therapy Assistants. Fees for services performed by physician assistants, nurse practitioners, medical social workers, nurse anesthetists, and physical therapy assistants are set at 75% of the amount that would otherwise be allowed by these rules and shall be billed using an 83 modifier.

B. Assistant Surgeons. Fees for assistant surgeons are limited as follows:

1. Medical doctors, osteopaths and podiatrists, designated with an -80 modifier, are to be paid 20% of the primary surgeon's fee;
2. Minimum paramedicals, designated with an -81 modifier, are to be paid 15% of the primary surgeon's value or 75% of the amount allowed under subsection B. 1., above.
3. When a qualified resident surgeon is not available, 20% of the primary surgeon's fee;
4. Other paramedical assistants, such as surgical assistants, are not billed separately.

C. Home health care. The following fees, which include mileage and travel time, are payable for Home Health Codes 99500 through 99602:

- | | |
|--------------------------------|---------------------------------------------|
| <u>1. RN</u> | <u>\$100/ 2 hours</u> |
| <u>2. LPN</u> | <u>\$75 / 2 hours</u> |
| <u>3. Home Health Aide</u> | <u>\$25 / hour + \$6 additional 30 min.</u> |
| <u>4. Speech Therapists</u> | <u>\$80 / visit</u> |
| <u>5. Physical Therapy</u> | <u>\$125/ hour</u> |
| <u>6. Occupational Therapy</u> | <u>\$125/ hour</u> |

7. Home Infusion Providers are to be paid according to contract between the payor and home infusion provider. In no contract is established, the payor shall pay the amount specified in Days Guidelines and pay UCR or Cost + 15% for the drugs and supplies.

D. Acupuncturists, naturopathic providers and massage therapy. Payor preauthorization is required for any services provided by acupuncturists and naturopaths. Payment for massage therapy is only allowed when administered by a medical provider and billed according to the requirements of R612-300. 5. C, "Restorative Services."

E. Ambulance. Ambulance charges are limited to the rates set

by the State Emergency Medical Service Commission.

R612-300-7. Billing and Payment.

A. Billing Limitations.

1. Except as otherwise provided by a specific provision of the Workers' Compensation Act or these rules, an injured worker may not be billed for the cost of medical care necessary to treat his or her workplace injuries.

2. A health care provider may not submit a bill for medical care of an injured worker to both the employer and the insurance carrier.

B. Discounting and down-coding.

1. Discounting or reducing the fees established by these rules is permitted only pursuant to a specific contract between the medical provider and payor.

2. A payor may change the CPT code submitted by a health care provider under the following circumstances:

a. The submitted code is incorrect;

b. Another code more closely identifies the medical care;

c. The medical provider has not submitted the documentation necessary to support the code; or

d. The medical care is part of a larger procedure and included in the fee for that procedure.

3. If a payor changes a code number, the payor shall explain the reason for the change and provide the name and phone number of the payor's claims processor to the medical provider in order to allow further discussion.

C. Place of Treatment. A medical provider's billing for a medical procedure must identify the setting where a procedure was performed.

1. In an office or clinic: Fees for procedures performed in an office or clinic are to be computed using the Non-Facility Total RVU.

2. In a facility setting: Fees for physician services for procedures performed in a facility are to be computed using the "Facility Total RVU," as the facility will be billing for the direct and indirect costs related to the service.

D. Separate Bills. Separate bills must be presented by each medical provider within 30 days of treatment on a HCFA 1500 billing form. All bills must contain the federal ID number of the provider submitting the bill.

E. Hospital Fees.

1. The Labor Commission does not have authority to set fees for hospital care of injured workers. However, hospitals are subject to the Commission's reporting requirements, and fees charged by health care providers for services performed in a hospital are subject to the Commission's fee regulations.

2. Fees covering hospital care shall be separate from those for professional services and shall not extend beyond the actual necessary hospital care.

3. All billings must be submitted on a UB92 form, properly itemized and coded, and shall include all documentation, including discharge summary, necessary to support the billing. No separate fee may be charged for billing or documentation of hospital services.

F. Charges for Supplies, Materials, or Drugs.

1. Ordinary supplies, materials or drugs used in treatment shall not be charged separately but shall be included in the amount allowed for the underlying medical care.

2. Special or unusual supplies, materials, or drugs not included as a normal and usual part of the service or procedure may be billed at cost plus 15% restocking fees and any taxes paid.

G. Miscellaneous.

1. A physician may bill the new patient E&M code when seeing an established patient for a new work injury.

2. Payment for hospital care is limited to the bed rate for semi-private room unless a private room is medically necessary.

3. Non-facility RVS total unit values apply, except that procedures provided in a facility setting shall be reimbursed at the facility total unit value and the facility may bill a separate facility charge.

4. Items that are a portion of an overall procedure are NOT to be itemized or billed separately.

5. Payors may round charges to the nearest dollar. If this is done on some charges, it must be done with all charges.

H. Prompt Payment and Interest.

1. All bills for medical care of injured workers must be paid within 45 days of submission to the payor unless the bill or some portion of the bill is in dispute. Any portion of the bill not in dispute; remains payable within 45 days of billing.

2. As required by Section 34A-2-420 of the Utah Workers' Compensation Act, any award for medical care made by the Commission shall include interest at 8% per annum from the date of billing for such the medical care.

I. Billing Disputes. Payors and health care providers shall use the following procedures to resolve billing disputes.

1. The provider shall submit a bill for services with supporting documentation to the payor within one year of the date of service.

2. The payor shall evaluate the bill and pay the appropriate fee as established by these rules.

3. If the provider believes the payor has improperly computed the fee, the provider may submit a written request for reevaluation to the payor. The request shall describe the specific areas of disagreement and include all appropriate documentation. Any such request for re-evaluation must be submitted to the payor within one year of the date of the original payment.

4. Within 30 days of receipt of the request for re-evaluation, the payor shall either pay the additional fee due the provider or respond with a specific written explanation of the basis for its denial of additional fees. The payor shall maintain proof of transmittal of its response.

5. A payor seeking reimbursement from a provider for overpayment of a bill shall, within one year of the overpayment, submit to the provider a written request for repayment that explains the basis for request. Within 90 days of receipt of the request, the provider shall either make appropriate repayment or respond with a specific written denial of the request.

6. If the provider and payor continue to disagree regarding the proper fee, either party may request informal review of the matter

by the Division. Any party may also file a request for hearing on the dispute with the Adjudication Division.

R612-300-8. Travel Allowance For Injured Workers.

A. Payment for Travel to Obtain Medical Care. An injured worker who must travel outside his or her community to obtain necessary medical care is entitled to payment of meals, lodging and other travel expense. Payors shall reimburse injured workers for these expenses according to the standards set forth in State of Utah Accounting Policies and Procedures, Section FIACCT 10-02.00, "Travel Reimbursement".

1. All travel must be by the most direct route and to the nearest location where adequate treatment is reasonably available.

2. Travel may not be required between the hours of 10:00 p.m. and 6:00 a.m., unless approved by the Commission.

B. Time Limits for Requesting and Paying Travel Expenses.

1. Requests for travel reimbursement must be submitted to the payor for payment within one year after the subject travel expenses were incurred;

2. The payor must pay an injured employee's travel expenses at the earlier of:

a. Every three months;

b. Upon accrual of \$100 in such expense; or

c. At closure of the injured worker's claim.

R612-300-9. Permanent Impairment Ratings.

A. Utah's 2006 Impairment Guides. The "Utah 2006 Impairment Guides" are incorporated by reference and are to be used to rate a permanent impairment not expressly listed in Section 34A-2-412 of the Utah Workers' Compensation Act.

B. American Medical Association's "Guides to the Evaluation of Permanent Impairment, Fifth Edition." For those permanent impairments not addressed in either Section 34A-2-412 or the "Utah 2006 Impairment Guides," impairment ratings are to be established according to the American Medical Association's "Guides to the Evaluation of Permanent Impairment, Fifth Edition."

R612-300-10. Medical Records.

A. Relationship between HIPAA and Workers' Compensation Disclosure Requirements. Workers' compensation insurers, employers and the Utah Labor Commission need access to health information of individuals who are injured on the job or who have a work-related illness in order to process or adjudicate claims, or to coordinate care under Utah's workers' compensation system. Generally, this health information is obtained from health care providers who treat these individuals and who may be covered by federal "HIPAA" privacy rules.

The HIPAA Privacy Rule specifically recognizes the legitimate need of the workers' compensation system to have access to individuals' health information to the extent authorized by State law. See 45 CFR 164.512(1). The Privacy Rule also recognizes the importance of permitting disclosures required by other laws. See 45 CFR 164.512(a). Therefore, disclosures permitted by this rule

for workers' compensation purposes or otherwise required by this rule do not conflict with and are not prohibited by the HIPAA Privacy Rule.

B. Disclosures Permitted Without Authorization. A medical provider, without authorization from the injured workers, shall:

1. For purposes of substantiating a bill submitted for payment or filing required Labor Commission forms, such as the "Physician's Initial Report of Injury/Illness" or the "Restorative Services Authorization," disclose medical records necessary to substantiate the billing, including drug and alcohol testing, to:

a. An employer's workers' compensation insurance carrier or third party administrator;

b. A self-insured employer who administers its own workers' claims.

c. The Uninsured Employers' Fund;

d. The Employers' Reinsurance Fund; or

e. The Labor Commission as required by Labor Commission rules.

2. Disclose medical records pertaining to treatment of an injured worker who makes a claim for workers' compensation benefits, to another physician for specialized treatment, to a new treating physician chosen by the claimant, or for a consultation regarding the claimed work related injury or illness.

C. Disclosures Requiring Authorization.

1. Except as limited in C(3), a medical provider, whose medical records are relevant to a worker's compensation claim, shall, upon receipt of a Labor Commission medical records release form, or an authorization form that conforms to HIPAA requirements, disclose his/her medical records to:

a. An employer's insurance carrier or third party administrator;

b. A self-insured employer who administers its own workers' compensation claims;

c. An agent of an entity listed in B(1)(a through e), which includes, but is not limited to a case manager or reviewing physician;

d. The Uninsured Employers Fund;

e. The Employers' Reinsurance Fund;

f. The Labor Commission;

g. The injured workers;

h. An injured workers' personal representative;

i. An attorney representing any of the entities listed above in an industrial injury or occupational disease claim.

2. Medical records are relevant to a workers' compensation claim if;

a. The records were created after the reported date of the accident or onset of the illness for which workers' compensation benefits have been claimed; or

b. the records were created in the past ten years (15 years if permanent total disability is claimed) and:

i. There is a specific reason to suspect that the medical condition existed prior to the reported date of the claimed work related injury or illness or;

ii. The claim is being adjudicated by the Labor Commission.

3. Medical records related to care provided by a psychiatrist, psychologist, obstetrician, or care related to the reproductive organs may not be disclosed by a medical provider unless a claim has been made for a mental condition, a condition related to the reproductive organs, or the claimant has signed a separate, specific release for these records.

D. Disclosure Regarding Return to Work. A medical provider, who has treated an injured worker for a work related injury or illness, shall disclose information to an injured workers' employer as to when and what restrictions an injured worker may return to work.

E. Additional Disclosures Requiring Specific Approval. Requests for medical records beyond what sections B, C, and D permit require a signed approval by the director, the medical director, a designated person(s) within the Industrial Accidents Division or an administrative law judge if the claim is being adjudicated.

F. Appeals. A party affected by the decision made by a person in section E may appeal that decision to the Adjudication Division of the Labor Commission.

G. Injured Worker's Duty to Disclose Medical Treatment and Providers. Upon receipt and within the scope of this rule, an injured worker shall provide those entities or persons listed in C(1) the names, address, and dates of medical treatment (if known) of the medical providers who have provided medical care within the past 10 years (15 years for permanent total disability claim) except for those medical providers names in C(3). Labor commission form number 307 "Medical Treatment Provider List" must be used for this purpose. Parties listed in C(1) of this rule must provide each medical provider identified on form 307 with a signed authorization for access to medical records. A copy of the signed authorization may be sent to the medical providers listed on form 307.

H. Injured Worker's Right to Contest Requests for Pre-Injury Medical Records. An injured worker may contest, for good reason, a request for medical records created prior to the reported date of the accident or illness for which the injured worker has made a claim for benefits by filing a complaint with the Labor Commission. Good reason is defined as the request has gone beyond the scope of this rule or sensitive medical information is contained in a particular medical record.

I. Limitations on Use and Re-disclosure of Medical Information.

1. Any party obtaining medical records under authority of this rule may not disclose those medical records, without a valid authorization, except as required by law.

2. An employer may only use medical records obtained under the authority of this rule to:

a. Pay or adjudicate workers' compensation claims if the employer is self-insured;

b. To assess and facilitate an injured workers' return to work;

c. As otherwise authorized by the injured worker.

3. An employer obtaining medical records under authority of this rule must maintain the medical records separately from the employee's personnel file.

4. Any medical records obtained under the authority of this rule to make a determination regarding the acceptance of liability or for treatment of a condition related to a workers' compensation claim shall only be used for workers' compensation purposes and shall not be released, without a signed release by the injured worker or his/her personal representative, to any other party. An employer shall make decisions related only to the workers' compensation claim based on any medical information received under this rule.

K. Permissible Fees for Providing Medical Records. When any medical provider provides copies of medical records, other than the records required when submitting a bill for payment or as required by the Labor Commission rules, the following charges are presumed reasonable:

1. A search fee of \$15 payable in advance of the search;

2. Copies at \$.50 per page, including copies of microfilm, payable after the records have been prepared and

3. Actual costs of postage payable after the records have been prepared and sent. Actual cost of postage are deemed to be the cost of regular mail unless the requesting party has requested the delivery of the records by special mail or method.

4. The Labor Commission will release its records per the above charges to parties/entities with a signed and notarized release from the injured worker unless the information is classified and

controlled under the Government Records Access and Management Act (GRAMA).

5. No fee shall be charged when the RBRVS or the Commission's Medical Fee Guidelines require specific documentation for a procedure or when medical providers are required to report by statute or rule.

6. An injured worker or his/her personal representative may obtain one copy of each of the following records related to the industrial injury or occupational disease claim, at no cost, when the injured worker or his/her personal representative have signed a form by the Industrial Accidents Division to substantiate his/her industrial injury/illness claim;

a. History and physical;

b. Operative reports of surgery;

c. Hospital discharge summary;

d. Emergency room records;

e. Radiological reports;

f. Specialized test results; and

g. Physician SOAP notes, progress notes, or specialized reports.

h. Alternatively, a summary of the patients records may be made available to the injured worker or his/her personal representative at the discretion of the physician.

R612-300-11. Utilization Review Standards.

A. Purpose of Utilization Review and Definitions.

1. "Utilization Review" is used to manage medical costs, improve patient care and enhance decision-making. Utilization review includes, but is not limited to, the review of requests for authorization and the review of medical bills to determine whether the medical services were or are necessary to treat a workplace injury. Utilization review does not include:

a. bill review for the purpose of determining whether the medical services rendered were accurately billed, or

b. any system, program, or activity used to determine whether an individual has sustained a workplace injury.

2. Any utilization review system shall incorporate a two-level review process that meets the criteria set forth in subsections B and C of this rule.

3. Definitions. As used in this rule:

a. "Request for Authorization" means any request by a physician for assurance that appropriate payment will be made for a course of proposed medical treatment.

b. "Reasonable Attempt" requires at least two phone calls and a fax, or three phone calls, within five business days from date of the payor's receipt of the physician's request for review.

B. Level I - Initial Request and Review.

1. A health care provider may use Form 223 to request authorization and payment for proposed medical treatment. The provider shall attach all documentation necessary for the payor to make a decision regarding the proposed treatment.

a. Requests for approval of restorative services are governed by the provisions of Rule R612-300.5. C. 7. which requires submission of the appropriate RSA form and documentation.

2. Upon receipt of the provider's request for authorization, the payor may use medical or non-medical personnel to apply medically-based criteria to determine whether to approve the request. The payor must:

a. Within 5 business days after receiving the request and documentation, transmit Form 223 back to the physician, in a verifiable manner, advising of the payor's approval or denial of the proposed treatment.

i. If approval is denied, the payor must include with its denial a statement of the criteria it used to make its determination. A copy of the denial must also be mailed to the injured worker.

C. Level II - Review.

1. A health care provider who has been denied authorization or has received no timely response may request a physician's review by completing and sending the applicable portion of Commission Form 223 to the payor.

a. The provider must include the times and days that he/she is available to discuss the case with the reviewing physician, and must be reasonably available during normal business hours.

b. This request for review may be used by a health care provider who has been denied authorization for restorative services pursuant to Rule R612-300-5. C.7.

2. The payor's physician representative must complete the review within five business days of the treating physician's request for review. Additional time may be requested from the Commission to accommodate highly unusual circumstances or particularly difficult cases.

a. The insurer's physician representative must make a reasonable effort to contact the requesting provider to discuss the request for treatment. The payor shall notify the Commission if an additional five days is needed in order to contact the treating physician or to review the case.

b. If the payor again denies approval of the recommended treatment, the payor must complete the appropriate portion of Commission Form 223, and shall included:

i. the criteria used by the payor in making the decision to deny authorization; and

ii. the name and specialty of the payor's reviewing physician;

iii. appeals information.

c. The denial to authorize payment for treatment must then be sent to the physician, the injured worker and the Commission.

3. The payor's failure to respond to the review request within five business days, by a method which provides certification of transmission, shall constitute authorization for payment of the treatment.

C. Mediation and Adjudication. Upon receipt of denial of authorization for payment for medical treatment at Level II, the Commission will facilitate, upon the request of the injured worker, the final disposition of the case.

1. If the parties agree, the medical dispute will be referred to Commission staff for mediation.

2. If the parties do not agree to mediation, the matter will be referred to the Division of Adjudication for hearing and decision.

D. Reduction of Fee for Failure to Follow Utilization Review Standards.

1. In cases in which a health care provider has received notice of this rule but proceeds with non-emergency medical treatment without obtaining payor authorization, the following shall apply:

a. If the medical treatment is ultimately determined to be necessary to treat a workplace injury, the fee otherwise due the health care provider shall be reduced by 25%.

b. If the medical treatment is ultimately determined to be unnecessary to treat a workplace injury, the payor is not liable for payment for such treatment. The injured worker may be liable for the cost of treatment.

2. The penalty provision in D. 1. shall not apply if the medical treatment in question has been preauthorized by some other non-worker's compensation insurance company or other payor.

R612-300-12. Commission Approval of Health Care Treatment Protocols.

A. Authority. Pursuant to authority granted by Section 34A-2-111(2)(c)(i)(B)(VII) of the Utah Workers' Compensation Act, the Utah Labor Commission establishes the following standards and procedures for Commission approval of medical treatment and quality care guidelines.

B. Standards

1. Scientifically based: Section 34A-2-111(2)(c)(i)(B)(VII)(Aa) of the Act requires that guidelines be scientifically based. The Commission will consider a guideline to be "scientifically based" when it is supported by medical studies and/or research.

2. Peer reviewed: Section 34A-2-111(2)(c)(i)(B)(VII)(Bb) of the Act requires that guidelines be peer reviewed. The Commission will consider a guideline to be "peer reviewed" when the medical study's content, methodology, and results have been reviewed and approved prior to publication by an editorial board of qualified experts".

3. Other standards: Pursuant to its rulemaking authority under Section 34A-2-111(2)(c)(i)(B)(VII), the Utah Labor Commission

establishes the following additional standards for medical treatment and quality care guidelines.

a. The guidelines must be periodically updated and, subject to Commission discretion, may not be approved for use unless updated in whole or in part at least biannually;

b. Guideline sources must be identified;

c. The guidelines must be reasonably priced;

d. The guidelines must be easily accessible in print and electronic versions.

C. Procedure: Pursuant to Section 34A-2-111(2)(c)(i)(B)(VII) of the Utah Workers' Compensation Act, a party seeking Commission action to approve or disapprove a guideline shall file a petition for such action with the Labor Commission.

R612-300-13. HIV, Hepatitis B and C Testing and Reporting for Emergency Medical Service Providers.

A. Purpose and Authority. This rule, established pursuant to U.C.A. Section 78B-8-404, establishes procedures for testing and reporting following a significant exposure of an emergency medical services provider to infectious diseases.

B. Definitions. In addition to the terms defined in Section 78B-8-401, the following definitions apply for purposes of this rule.

1. Contact means designated person(s) within the emergency medical services agency or the employer of the emergency medical services provider.

2. Emergency medical services (EMS) agency means an agency, entity, or organization that employs or utilizes emergency medical services providers as defined in (4) as employees or volunteers.

3. Source Patient means any individual cared for by a pre-hospital emergency medical services provider, including but not limited to victims of accidents or injury, deceased persons, and prisoners or persons in the custody of the Department of Corrections.

4. Receiving facility means a hospital, health care or other facility where the patient is delivered by the emergency medical services provider for care.

C. Emergency Medical Services Provider Responsibility.

1. The EMS provider shall document and report all significant exposures to the receiving facility and contact as defined in C.

2.

2. The reporting process is as follows:

a. The exposed EMS provider shall complete the Exposure Report Form (ERF) at the time the patient is delivered to the receiving facility and provide a copy to the person at the receiving facility authorized by the facility to receive the form. In the event the exposed EMS provider does not accompany the source patient to the receiving facility, he/she may report the exposure incident, with information requested on the ERF, by telephone to a person authorized by the facility to receive the form. In this event, the exposed EMS provider shall nevertheless submit a written copy of the ERF within three days to an authorized person of the receiving facility.

b. The exposed EMS provider shall, within three days of the incident, submit a copy of the ERF to the contact as defined in C.

2.

D. Receiving Facility Responsibility.

1. The receiving facility shall establish a system to receive ERFs as well as telephoned reports from exposed EMS providers on a 24-hour per day basis. The facility shall also have available or on call, trained pre-test counselors for the purpose of obtaining consent and counseling of source patients when HIV testing has been requested by EMS providers. The receiving facility shall contact the source patient prior to release from the facility to provide the individual with counseling or, if unable to provide counseling, provide the source patient with phone numbers for a trained counselor to provide the counseling within 24 hours.

2. Upon notification of exposure, the receiving facility shall request permission from the source patient to draw a blood sample for disease testing, as defined in C. 3. In conjunction with this request, the source patient must be advised of his/her right to refuse testing and be advised that if he/she refuses to be tested that fact will be forwarded to the EMS agency or employer of EMS provider. The source patient shall also be advised that if he/she refuses to be tested, the EMS agency or provider may seek a court order to compel the source patient to submit to a blood draw for the disease testing. Testing is authorized only when the source patient, his/her next of kin or legal guardian consents to testing, with the exception that consent is not required from an individual who has been convicted of a crime and is in the custody or under the jurisdiction of the Department of Corrections, or if the source patient is dead. If consent is denied, the receiving facility shall complete the ERF and send it to the EMS agency or employer of the EMS provider. If consent is received, the receiving facility shall draw a sample of the source patient's blood and send it, along with the ERF, to a qualified laboratory for testing.

3. The laboratory that the receiving facility has sent source patient's blood draw to shall send the disease test results, by Case ID number, to the EMS agency or employer of the EMS provider.

F. EMS Agency/Employer Responsibility:

1. The EMS agency/employer, upon receipt of the disease tests, from the receiving facility laboratory, shall immediately report the result, by case number, not name, to the exposed EMS provider.

2. The EMS agency/employer, upon the receipt of refusal of testing by the source, shall report that refusal to the EMS provider.

3. The agency/employer or its insurance carrier shall pay for the EMS provider and the source patient testing for the covered diseases per the Labor Commission fee schedule.

4. The EMS agency/employer shall maintain the records of any disease exposures contained in this rule per the OSHA Blood Borne Pathogen standards.

KEY: workers' compensation, fees, medical practitioners

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