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Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Tennessee Department of Labor and Workforce Development
Division:	Bureau of Workers' Compensation
Contact Person:	Troy Haley
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Phone:	615-532-0179
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(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to http://state.tn.us/sos/rules/1360/1360.htm)

Revision Type (check all that apply):
X Amendment
___ New
___ Repeal

Rule(s) (**ALL** chapters and rules contained in filing must be listed. If needed, copy and paste additional tables to accommodate more than one chapter. Please enter only **ONE** Rule Number/Rule Title per row.)

Chapter Number	**Chapter Title**
0800-02-14	Claims Handling Standards
Rule Number	**Rule Title**
0800-02-14-.01	Scope of Rules
0800-02-14-.02	Definitions
0800-02-14-.03	General Requirements
0800-02-14-.04	Claims Reporting Requirements
0800-02-14-.05	Claims Handling and Investigating
0800-02-14-.06	Payment of Benefits
0800-02-14-.07	Medical Costs
0800-02-14-.08	Resolution Process
0800-02-14-.09	Claims Resolution Filing Requirements
0800-02-14-.10	Enforcement
0800-02-14-.11	Fraud

Chapter 0800-02-14
Claims Handling Standards
Amendments

Chapter 0800-02-14 Claims Handling Standards is amended by deleting the prior rule and replacing it with the following:

0800-2-14-.01 Scope of Rules

The provisions of this chapter shall apply to all employers, adjusting entities and providers of services related to workers' compensation claims in the State of Tennessee subject to provisions of the Workers' Compensation Law.

Authority: T.C.A. §§ 50-6-233, 50-6-415, 50-6-419.

0800-2-14.02 Definitions

(1) "Adjusting entity" means a trade or professional association, managing general agency, pool, third party administrator and/or insurance company licensed to write workers' compensation insurance in Tennessee and shall also mean a self-insured employer or group self-insured employers possessing a valid certificate of authority from the commissioner of commerce and insurance pursuant to T.C.A. § 50-6-405.

(2) "Adjuster", "claims adjuster", "med-only adjuster", or "claims handler" means a representative of an adjusting entity who investigates workers' compensation claims for the purposes of making compensability determinations, files or causes claims forms to be filed with the Bureau, commences benefits, and/or makes settlement recommendations based on the insured's liability on behalf of a self-insured employer, trade or professional association, third party administrator, and/or insurance company.

(3) "Administrator" shall have the same definition of "Administrator" as in T.C.A. § 50-6-102.

(4) "Bureau" means the Tennessee Bureau of Workers' Compensation as defined in T.C.A. § 50-6-102, an autonomous unit attached to the Department of Labor and Workforce Development for administrative matters only, pursuant to T.C.A. § 4-3-1409.

(5) "Claim" means a demand for something as due; an assertion of a right or an alleged right.

(6) "Electronic Data Interchange" or "EDI" means the electronic communication method that provides standards for exchanging data via electronic means. The term "EDI" encompasses the entire electronic data interchange process, including the transmission, message flow, document format, and software used to interpret the documents using the standards established by the IAIABC and the Release Version accepted by the Bureau at the time of the filing.

(7) "Electronic Form Equivalent" means the original document, provided on the Bureau's website, which is to be used when a sender reports required data via a paper document. When forms are reproduced, they shall be reproduced in their entirety, including instructions and shall not be modified without written consent of the Administrator. A form may be revised at any time at the discretion of the Administrator and will be available at no cost.

(8) "Employee" shall have the same definition of "Employee as in T.C.A. § 50-6-102.

(9) "Employer" shall have the same definition of "Employer" as in T.C.A. § 50-6-102.

(10) "First Report of Work Injury" means the EDI equivalent of the form available on the Bureau's website and designated by the Bureau as the appropriate document to initially report a claim of injury.

(11) "Form" means the document as is available on the Bureau's website on the date of the filing.

(12) "IAIABC" means the International Association of Industrial Accident Boards and Commissions.

(13)"Injury" and "personal injury" shall have the same definition of "injury" as in T.C.A. § 50-6-102.

(14)"Insured" shall have the same definition of "Employer" as in T.C.A. § 50-6-102.

(15)"Medical-only" claim or "med-only" claim means a claim requiring medical attention, but which has no indemnity benefits due or paid. Any claim in which no indemnity benefits are due or paid, but which has medical treatment provided by any medical personnel qualifies the claim for medical only status, regardless of whether or not a bill is generated and regardless of whom pays for the medical care.

(16)"Trading partner" means an entity approved by the Bureau to exchange data electronically with the Bureau on behalf of an adjusting entity.

Authority: T.C.A. §§ 50-6-102, 50-6-233 and 50-6-113.

0800-2-14-.03 General Requirements

(1) Any employer or adjusting entity that knowingly, willfully and intentionally causes a claim to be paid under any health or sickness and accident insurance or that fails to provide reasonable and necessary medical treatment, including a failure to reimburse when the employer or adjusting entity knew that the claim arose out of a compensable work-related injury shall be assessed a civil penalty of $500.00. The employer or adjusting entity shall not offset any benefit paid by that insurance against its temporary total disability benefit liability.

(2) Each adjusting entity shall designate at least one contact person to serve as a liaison between the entity and the Bureau. The designee must have the ability to provide information about claims assignments, status of payments and contact information for the adjusting entity's adjusters as well as the entity's primary EDI contact. The designee's name, title, direct phone number, email address, and mailing address shall be provided to the Bureau, on a form prescribed by the Bureau, in January of each year and within fifteen (15) calendar days of any change regarding the designee for that entity. Each January and July, the designee shall provide the Bureau, on a form prescribed by the Bureau, with the name(s), direct phone number(s), email address(es), and mailing address(es) for each individual adjuster that is performing duties covered by these Rules. Each separate act of not timely notifying the Bureau of a change in the designee or not timely providing the information required in this subsection regarding adjusters shall constitute a separate violation and may subject the entity to assessment of a civil penalty, per Rule 0800-02-01-.10, for each separate act.

(3) If an adjusting entity contracts with a trading partner to electronically file transactions with the Bureau on the entity's behalf, or uses a trading partner's software product for electronically sending transactions to the Bureau, a Trading Partner Agreement form, provided by the Bureau, must be fully completed and submitted to the Bureau. The adjusting entity shall remain responsible for the timely filing of transactions required by this rule, processing of acknowledgements, and any penalties and fines that may result from untimely electronic filings.

(4) All adjusting entities or trading partners shall utilize anti-virus software to remove any viruses on all electronic transmissions prior to sending electronic transmissions to the Bureau. The adjusting entity or trading partner shall maintain the anti-virus software with the most recent anti-virus update files from the software provider. If the adjusting entity or trading partner sends a transmission that contains a virus which prevents the Bureau from processing the transmission, the transmission will not be considered as having been received.

Authority: T.C.A. §§ 50-6-128, 50-6-233, 50-6-415, 50-6-419, and 56-47-103 and 50-3-702.

0800-2-14-.04 Claims Reporting Requirements

(1) All forms required by these rules must be filed with the Bureau via EDI, unless an electronic form equivalent is specifically allowed or required by the Bureau. Requirements for EDI reporting are posted on the Bureau's website.

(2) The adjuster, when required, shall include the following information on every form it submits to the Bureau:

(a) The employee's name.
(b) The employee's date of birth.
(c) The month, day, and year of the employee's injury or illness, in the following order: mm-dd-yy or mm-dd-yyyy.
(d) The employee's social security number (SSN) as assigned by the Social Security Administration.
    i. If the employee does not have a SSN, the adjusting entity shall assign an identification number that begins with the number "9" and is followed by the employee's date of birth, in the following format 9MMDDYYYY.
    ii. If the adjusting entity later learns the correct SSN, the adjusting entity shall immediately notify the Bureau via EDI by filing the appropriate FROI Change of SSN notice.

(3) The adjusting entity shall ensure that all documents filed with the Bureau pursuant to this chapter, either by EDI or electronic form equivalent, are complete and legible.

(a) If a filing is not complete and error free, the filing shall be rejected. The adjusting entity shall make the correction, and resubmit the filing to the Bureau. The filing will be considered "accepted" and in compliance with this section only when a complete and error free filing is received and not rejected by the Bureau.
(b) An adjusting entity will be subject to a penalty for any calendar month in which it fails to successfully transmit its documents with at least an 85% acceptance by the Bureau success rate for its filings. The assessment of this penalty will not preclude the assessment of additional penalties outlined in Rules 0800-02-13.

(4) Every adjusting entity shall submit Tennessee's First Report of Work Injury form to the Bureau as soon as possible in all cases where the reported injury results in the need for medical treatment, restricted work, the inability to work, or death, but no later than the time frames listed below.

(a) Reports of all injuries causing seven (7) calendar days of disability or fewer shall be submitted on or before the fifteenth (15th) day of the month following the month in which the injury occurred.
(b) Injuries that result in death or a personal injury of a nature that the injured employee did not return to the employee's employment within seven (7) calendar days after the occurrence of the injury must be reported no later than fourteen (14) calendar days after the report by an employer of the occurrence of the injury.
(c) Minor injuries such as scratches, scrapes, paper cuts and/or other injuries treated solely by minor first aid are not required to be reported to the Bureau. More serious injuries such as sprains, strains or bruising must be reported.

(5) Within two (2) business days of receiving a verbal or written notice of any injury from an employer, the adjusting entity shall send a Notice of a Reported Injury and a copy of the Beginner's Guide to Tennessee Workers' Compensation on the forms prescribed by the Administrator to each employee's last known address via first class US Mail.

(6) Decisions on compensability shall be made by the adjusting entity within fifteen (15) calendar days of the verbal or written notice of injury. If after conducting a reasonable investigation as required by these rules a claim is denied, the adjusting entity must notify the Bureau within five (5) business days of reaching that decision by filing the Notice of Denial of Claim for Compensation and must provide the employee or their representative, the treating physician and the insured a non-EDI version of the Notice of Denial, available on the Bureau's website, simultaneously with the notification to the Bureau. The notice must include the basis for the denial.

(7) Adjusting entities must file the First Report of Payment of Compensation with the Bureau within five (5) business days of the initial payment of benefits and shall submit the Notice of Change or Termination of Compensation Benefits within five (5) business days of a change or termination of the payment of compensation benefits. The adjusting entity must also provide the employee or their representative and the insured a non-EDI version of the Notice of Change or Termination of Compensation Benefits simultaneously with the notification to the Bureau and must provide the explanation of the rationale upon which the changes were based.

(8) An adjusting entity electing to controvert its liability and terminate the payment of compensation benefits after temporary disability and/or medical benefits have been paid in a claim, shall submit a Notice of Controversy to the Bureau within fifteen (15) calendar days of the due date of the first omitted payment.

Authority: T.C.A. §§ 50-6-233, 50-6-415, and 50-6-419.

0800-2-14-.05 Claims Handling and Investigation

(1) The adjuster shall make verbal or written contact with the employee within two (2) business days of receiving a verbal or written notice of any injury, including those considered to be "medical-only". For "medical-only" claims, this contact is satisfied by the mailing of the Notice of Reported Injury referenced herein. In claims that involve lost time from work, this contact is not satisfied by the mailing of the Notice of a Reported Injury referenced herein. The purpose of this contact is to:

(a) Provide each employee with the adjuster's name and contact information, which shall include the adjuster's direct phone number, fax number, email address, and mailing address; and,

(b) Investigate the facts of the claim and obtain a history of prior claims, including work history, wages, and job duties.

(2) Adjusters shall make personal, written or telephone contact with the employer within two (2) business days of the notice of the injury to verify details regarding the claim.

(3) An adjuster assigned to a claim which had previously been assigned to a different adjuster shall make verbal or written contact with the employee within two (2) business days of the assignment and shall provide the employee with the newly assigned adjuster's name and contact information, which shall include that adjuster's direct phone number, fax number, email address, and mailing address. In instances involving a mass transfer of files, such as might occur if an adjusting entity purchased or merged with another adjusting entity, the time required to provide this notice will be extended to seven (7) business days.

(4) In claims when compensability is questioned, adjusters shall contact all authorized medical providers, or their staff members, who have rendered medical services to an employee within three (3) business days of an initial office visit to investigate details concerning the injury and treatment and make a preliminary compensability determination.

(5) All employers, adjusting entities and providers of services related to workers compensation claims in the State of Tennessee subject to provisions of the Workers' Compensation Law shall provide the Bureau all information and documentation that is requested, and only that information that is requested, for the purposes of monitoring, examining, or investigating the entity's operations and processes within ten (10) calendar days unless the Bureau allows an extension of time.

Authority: T.C.A. §§ 50-6-101, 50-6-233, 50-6-415, and 50-6-419.

0800-2-14-.06 Payment of Benefits

(1) Benefits are deemed paid when addressed to the last known address of the employee or dependent and deposited in the U.S. Mail or when funds are transferred to a financial institution for deposit in the employee's or dependent's account by approved electronic equivalent.

(2) All employees temporary total disability benefits shall be issued accurately and timely to assure the injured employee receives the benefits on or before the date they are due. To help ensure accuracy, Adjusters shall verify the average weekly wage of the employee with the employer consistent with the Bureau's requirements and the requirements of the Workers' Compensation Law. A Wage Statement, available on the Bureau's website, shall be filed with the Bureau upon request pursuant to Rule 0800-02-21-.10(3).

(a) To be considered timely, initial temporary total disability payments must be paid to the employee no later than fifteen (15) calendar days after the date the disability begins and every subsequent payment is made within consecutive fifteen (15) calendar day increments, until all temporary total benefits have been paid. Each payment must indicate the time period covered by the payment.

(3) All temporary partial disability benefits shall be issued timely, as per T.C.A § 50-6-207(2).

(4) Funeral expenses, including burial or cremation expenses, must be paid within a reasonable period of time, not to exceed thirty (30) days from the date of submission of invoice.

(5) All disability and death benefits shall be paid by check or direct deposit unless prior written permission for an alternative means of payment is given by the Administrator and the employee or employee's dependents have signed a written agreement allowing an alternative means.

Authority: T.C.A. §§ 50-6-201, 50-6-205, 50-6-225, 50-6-233, 50-6-409, and 50-6-419.

0800-2-14.07 Medical Costs

(1) All medical costs owed under the Tennessee Workers' Compensation Law shall be paid pursuant to the Medical Fee Schedule contained in Rules 0800-2-17, 0800-2-18 and 0800-2-19.

Authority: T.C.A. §§ 50-6-204, 50-6-233, 50-6-419.

0800-2-14-.08 Resolution Process

(1) The permanent impairment rating and date of maximum medical improvement determined by the treating physician, and other information needed to settle a claim shall be documented in writing on a form prescribed by the Administrator and provided, at no cost, to the employee within thirty (30) calendar days of its receipt by the adjuster.

(2) Adjusters shall make an offer of settlement in writing within thirty (30) calendar days of receipt of information specified above. If settlement is not agreed upon, a Benefit Review Conference or an Alternative Dispute Resolution, whichever is appropriate, may be requested by either party in accordance with the Bureau's rules.

(3) All settlements shall be reduced to writing and shall be finalized by order or approval of an appropriate court, as required by the Workers' Compensation Law. A copy of the court order or Bureau approval and appropriate Statistical Data Form shall be filed timely with the Bureau.

Authority: T.C.A. §§ 50-6-206, 50-6-233, 50-6-237, 50-6-240, 50-6-244, and 50-6-419.

0800-2-14-.09 Claims Resolution Filing Requirements

(1) The appropriate resolution form must be submitted to the Bureau in all claims when they are resolved.

(a) In matters concluded by settlement or resolved by trial, the employer or the employer's agent must file a fully-completed appropriate version of the Statistical Data Form contemporaneously with the filing of the final order or settlement.

1. To be considered fully complete, the form must contain all required data, as determined by the Bureau, and reflect information that is current as of the date the information is submitted to the court for approval, whether or not an appeal of the matter is anticipated or filed.

2. The employee and any agent of the employee must cooperate with the adjusting entities in completing the statistical data form.

(b) In matters not concluded by settlement or resolved by trial, adjusting entities must submit a fully-completed Final Report of Payment and Receipt of Compensation via EDI within thirty (30) days following the final payment of compensation. The form must report all compensation benefits paid on a

claim, including all medical expenses (including in-patient, out-patient, pharmacy, case management, therapy, etc.), death benefits and funeral expenses, and legal costs.

(2) A fully-completed Statistical Data Form is also required for every workers' compensation matter even if the only issue resolved is the closing of future medical benefits that had remained open pursuant to a prior order. This requirement applies even if a statistical data form was filed at the time of submission of the prior order.

(3) Pursuant to T.C.A. § 50-6-244, an order of the court is not final until the Statistical Data Form has been completed and filed with the appropriate clerk of the court or Bureau office.

(4) If the Administrator or the Administrator's designee determines that an employer or the employer's agent fails to fully complete or timely file the statistical data form, the bureau may assess a civil penalty against the offending party not to exceed one hundred dollars ($100) per violation. A party assessed a penalty by the Administrator pursuant to this subsection may appeal the penalty by requesting a contested case hearing pursuant to Rule 0800-02-.13.

Authority: T.C.A. §§ 50-6-206, 50-6-233, 50-6-244, and 50-6-419.

0800-2-14-.10 Enforcement

(1) The Bureau has the authority to monitor and audit the performance of adjusters and adjusting entities to ensure compliance with the Workers' Compensation Law and Bureau Rules as often as it deems necessary which includes, but is not limited to, the review of the following:

(a) Ongoing review of data provided to the Bureau by adjusting entities;
(b) Timeliness, completeness and accuracy of all filings with the Bureau in any format;
(c) Timeliness and accuracy of indemnity and/or payments to medical providers;
(d) Denied claims;
(e) Timeliness and accuracy of the provision of a panel of physicians;
(f) The alleged or suspected harassment, coercion or intimidation of any party;
(g) Timeliness of the response to a Request for Assistance, Petition for Benefits Determination or any equivalent form;
(h) Timeliness of the compliance with an Order from a Judge of the Court of Workers' Compensation Claims or Workers' Compensation Appeals Board, a Workers' Compensation Specialist, Administrative Law Judge, or an Administrator's Designee;
(i) Claims-handling practices;
(j) Timeliness of authorizing medical treatment and medications;
(k) Mailing of the Notice of a Reported Injury;
(l) Mailing of the Notice of Employer Rights and Responsibilities in a Workers' Compensation Claim required by Rule 0800-02-01 to the employer.

(2) Reports resulting from the Bureau's monitoring, examination or investigation conducted under this Chapter are considered public records and may be shared in any means deemed appropriate by the Bureau and may include publicizing those adjusting entities that exceed or fail to meet the Bureau's established thresholds for claims handling excellence.

(3) In addition to other penalties provided by applicable law and regulation, violations of any of the above rules shall be subject to enforcement by the Administrator pursuant to T.C.A. § 50-6-419(c).

Authority: T.C.A. §§ 50-6-233, 50-6-415 and 50-6-419.

0800-2-14-.11 Fraud

All provisions regarding the detecting, prosecuting, and/or preventing of workers' compensation fraud shall be governed by T.C.A. § 50-6-127 and Title 56, Chapter 47.

Authority: T.C.A. §§ 50-6-127, 50-6-419 and 56-47-103.

* If a roll-call vote was necessary, the vote by the Agency on these rules was as follows:

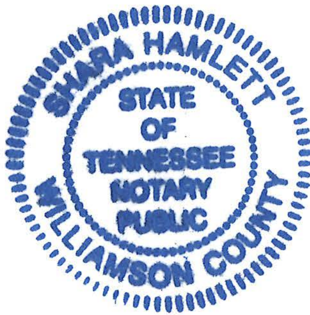
Board Member	Aye	No	Abstain	Absent	Signature (if required)

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Tennessee Bureau of Workers' Compensation on 12-22-17 and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on June 30, 2017.

Rulemaking Hearing Conducted on August 29, 2017.



Date: December 22, 2017

Signature: Abbie Hudgens

Name of Officer: Abbie Hudgens

Title of Officer: Administrator, Bureau of Workers' Compensation

Subscribed and sworn to before me on: December 22, 2017

Notary Public Signature: S. Hamlett

My commission expires on: 2/19/20

All proposed rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III
Herbert H. Slatery III
Attorney General and Reporter
4/30/2018
Date

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Department of State Use Only

Filed with the Department of State on: 5/4/18

Effective on: 8/2/18

Tre Hargett
Tre Hargett
Secretary of State

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

PUBLIC COMMENTS AND RESPONSES:

Comment: While we are aware of the statutory requirement that adjusting entities maintain an in-state claims office or contract with an in-state adjuster, this is an antiquated requirement that should not be the focus of limited enforcement resources. In-state claims handling is unnecessary and does not benefit injured workers.

Response: Legislation has been proposed to delete this statutory requirement, so the rule has been amended.

Comment: The time frames for filing the First Report of Payment of Compensation (within five business days of the initial payment of benefits) and the Notice of Change or Termination of Compensation Benefits (within one business day of a change or termination of the payment of compensation benefits) are far too short, and more stringent than in any other state.

Response: The bureau agrees in part and, upon review of research of the filing deadlines in other states, the time frame for filing the Notice of Change was changed to five business days.

Comment: TAA has a Worker's Compensation Pool, TENNESSEE AUTOMOTIVE ASSOCIATION SELF-INSURED TRUST (TAASIT) which provides primarily franchised motor vehicle dealers with worker's compensation insurance. TAASIT requests that you exempt their type of pools from the rules proposed by TDLWFD. It is a duplication of regulation and effort in many instances and is unnecessary in this instance.

Response: Self-insured employers and pools are subject to the workers' compensation law and rules. However, under Rule 0800-02-01-.04(3), self-insured employers and pools are exempt from this section, but must file proof of coverage with the Department of Commerce and Insurance in accordance with T.C.A. § 50-6-405 with a copy to the bureau.

Comment: Definition of Adjusting Entity should be modified to avoid conflation of TPA and payor concepts. Definition of Adjuster is too broad and may capture those who do not adjust claims but provide assistance or clerical services to adjusters.

Response: The bureau agrees in part, and the definitions have been amended.

Comment: In 14-.03(4), the filing of the Trading Partner Agreement form is unduly burdensome.

Response: The bureau disagrees that the filing is unduly burdensome.

Comment: In 14-.04 the EDI requirement should apply to the Adjusting Entity and not Adjuster.

Response: The bureau agrees and has made the change.

Comment: In 14-.04(3) this is a hard and fast rule acceptance percentage without taking into consideration the good or bad faith of the entity providing the information. 85% is too high and is dependent entirely on bureau's unilateral evaluation.

Response: The bureau disagrees. The 85% standard is in keeping with what other states do and was based upon a recommendation from the External Committee of representatives from carriers, employers and TPAs that was organized by the bureau prior to the drafting of these amended rules. Utah has an 85% standard. NY has a 90% standard. Virginia has a 90% goal.

Comment: In 14-.04(5), the Notice of Reported Injury and Beginner's Guide by mail introduces significant costs.

Response: The bureau agrees. A link will be provided for electronic access.

Comment: In 14-.04 (6) and (7), one business day to provide notice of denial, 5 business days to provide notice of first report of compensation to bureau, one business day to provide notice of change or termination is unreasonable. Also, sending non-EDI version of denial within time period is unreasonable.

Response: The bureau disagrees. Form filings with the Bureau must be done electronically. Time should not be an issue. Carriers must file the First Report of Injury within one day, so it should not create a problem to file a notice of denial within five days. There are 15 days to investigate. This rule only requires a carrier to electronically notify the bureau a day after they have completed their investigation and made their decision. Payments are not due until 15 days after disability begins. It should not be difficult to electronically notify within five days of ordering a check to be issued. Requiring carriers to notify injured employees at the same time that they notify the bureau is logical.

Comment: In 14-.05(1) sometimes it is not necessary to contact EE on minor, med only claims.

Response: The bureau agrees and the rule has been amended.

Comment: In 14-.05(3), delete as unnecessary. Many times the EE doesn't care who adjusts the claim and it has no impact on the ability to receive benefits, so long as phone number and mailing address do not change.

Response: The bureau disagrees. There have been many complaints from employees and from the general assembly about changes in the adjuster, not knowing who to contact, unable to reach anyone, etc.

Comment: In 14-.05(4), this introduces unnecessary costs into the system. Adjusting entities should be able to make a good faith determination as to compensability.

Response: The bureau disagrees with the comment regarding unnecessary costs being introduced into the system.

Comment: In 14-.05(5) a general provision like this regarding responding to bureau requests with penalty for non-responses may be denial of due process.

Response: The bureau disagrees and follows the procedures set forth in TCA § 50-6-118 and the bureau's rules for penalty assessments and hearing contested cases.

Comment: In 14-.06(4): No definition of reasonable has been provided for funeral expenses. Suggestion is 30 days of submission of acceptable invoice.

Response: The bureau agrees that 30 days from receipt of invoice is acceptable, and the change has been made.

Comment: In 14-.06(5), suggest the last sentence be deleted.

Response: The bureau agrees and the change has been made.

Comment: In 14-.08(1), fifteen days is too tight, suggestion is 30 days for Final Medical Report.

Response: The bureau agrees and the change has been made.

Comment: In 14-.08(2), 30 days is too tight for adjuster to make offer of settlement. Suggestion is 45 days. Also remove written requirement, as sometimes negotiations are verbal.

Response: The bureau disagrees. Thirty days is sufficient and the written requirement is valid.

Comment: In 14-.09(2), Clarify that SD1/SD2 form is only for settlements, otherwise it's too time consuming and too much paperwork.

Response: The SD1/SD2 is only for settlements.

Comment: In 14-.10, this broad enforcement/monitoring by bureau is inappropriate, especially for adjusting entities that are regulated by the Dept. of Commerce and Insurance.

Response: The bureau disagrees. We consulted with the Dept. of Commerce and Insurance. That department does not regulate the handling of individual claims by insurance adjusters and adjusting entities.

Comment: The proposed rule will significantly increase costs for insurers and TPAs currently maintaining out-of-state claims offices, as they would have to either create a claims office or contract with another adjuster in Tennessee. Increased costs will arise from maintaining multiple claims offices and/or contracting with an adjuster in Tennessee. The proposed rule will also limit a self-insured employer's ability to control which claims office handles its claims, as it may be forced to use a Tennessee claims office. Additionally, the rule does not foster increased efficiency or quality of claims administration. The quality and efficiency of claims administration is not dependent on the geographic location of adjusters and claims managers, considering the immediate and instant access to resources, submission of information, and exchange of written communication. The rule may actually eliminate highly competent claims professions from handling Tennessee claims. The in-state requirement is the biggest concern of her clients, due to excessive costs. Technology has progressed, so being physically present in TN should not be necessary to do a good job. Mediations and hearings could be attended via electronic means.

Response: The in-state claims office requirement is no longer required (PC 709 2018)). The rule has been amended.

Comment: In .06(5) there is concern that the last sentence is intended to address settlements via annuities or not.

Response: The bureau agrees and the sentence has been deleted.

Comment: T.C.A. §50-6-413 requires the workers' compensation insurer or self-insured employer to "maintain a workers' compensation claims office or to contract with a claims adjuster located within the borders of this state." The statute further requires that the claims office or adjuster has authority to commence benefits if so ordered by the Bureau or a court. The statute does not define "claims office" or specify personnel or claims functions to be carried out in the "claims office." The statute does not require that any claims be adjusted from the "claims office" and does not prohibit the adjustment of claims from outside the borders of Tennessee. Likewise, the statute does not require the in-state adjuster to perform any claims functions. There is no requirement for any claims functions to be performed in-state. The only requirement is that the claims office or adjuster has authority to commence temporary total disability benefits and medical benefits if so ordered by the claims coordinator or by a court at a show cause hearing. Importantly, T.C.A. §50-6-413 does not expressly give the Bureau any rulemaking authority to expand or reduce these statutory requirements. T.C.A. §50-6-419 expressly gives the Bureau limited rulemaking authority to set standards governing the adjustment and settlement of claims. Those standards may include, but not limited to, standards governing (1) contact with a employee, (2) processing of claims, and (3) procedures for making an offer of settlement. The agency authority is limited to setting standards governing adjustment and settlement of claims and does not extend to specifying where the claims processing takes place. These rules attempt to create an in-state adjusting requirement for Tennessee workers' compensation claims. This is beyond the scope of T.C.A. §§50-6-413 and 50-6-419. In addition, this is not in the best interests of system stakeholders. The competitive insurance market may be disrupted and policyholders hurt if foreign insurers leave or refuse to enter the Tennessee market because of this unnecessary administrative expense. Domestic insurers are hurt by this requirement if they can no longer use their Tennessee claims office to adjust claims in other jurisdictions due to state reciprocity requirements. Independent in-state adjusters are similarly hurt if they are no longer able to adjust claims in other jurisdictions because of state reciprocity requirements. The proposed in-state adjusting requirement serves no purpose. In general, claims processing takes place in offices with telephones and computers. There is no credible argument that a Nashville injured worker will receive superior claims handling from a claims office 212 miles away in Memphis, TN compared to a claims office 65 miles away in Bowling Green, KY. State borders and location are irrelevant to the quality of the claims handling process. Face-to-face contact with the injured worker is rarely needed in workers' compensation or other lines of property-casualty insurance. To the extent that face-to-face contact is needed, local claims professionals can be retained to perform the in-person services.

Response: The bureau agrees in part as to the lack of requirement for all TN claims to be adjusted from a TN claims office. The bureau does not agree that it is attempting to create an in-state adjusting requirement. That requirement is already in T.C.A. § 50-6-413 and a legislative change would be needed to amend or delete this statutory requirement. Note: The rule has been amended accordingly due to legislation passed (PC 709 (2018)).

Comment: The proposed rule does not provide for a phasing in or grace period from which the adjusting entity would be in compliance. The constitutionality of §50-6-413 is questioned in that it violates Article 1, Section 8, Clause 3 of the U.S. Constitution which gives Congress exclusive powers over interstate commerce. The enforcement of §50-6-413 would directly impact the ability to write business in the State of Tennessee. Carriers may not write enough business in Tennessee to afford an office in this state. Thus, some may be forced to withdraw from writing business in Tennessee altogether. The rules as written provide no mechanism for defining what type of contract would be necessary with an adjuster located within the borders of Tennessee. There is

similarly no definition of what constitutes being within the borders of Tennessee.

Response: The bureau disagrees regarding the constitutionality of T.C.A. 50-6-413, but the rule has been amended due to legislation (PC 709 2018)).

Comment: Proposed 0800-2-14-.02 Definitions... (8) "Claims Office" means a room, set of rooms, or building occupied by an adjuster where the commencement of workers' compensation benefits occurs.
The bureau does not have authority to set standards for a claims office or require that benefits be commenced from a claims office within the state. This definition should be deleted.

Response: The bureau agrees and has deleted this definition.

Comment: Proposed 0800-2-14-.03 General Requirements... (2) Pursuant to T.C.A. §50-6-413, every adjusting entity shall maintain a claims office within the borders of Tennessee or shall be required to contract with an adjuster within the borders of Tennessee....This requirement is not met by an adjusting entity having merely a Tennessee mailing address, post office box or similar receptacle to receive mail that is located within the borders. The bureau does not have authority to set standards for a claims office or require that benefits be commenced from a claims office within the state. This subsection should be deleted.

Response: The bureau agrees.

Comment: Proposed 0800-2-14-.02 Definitions... (8) "Claims Office" means a room, set of rooms, or building occupied by an adjuster where the commencement of workers' compensation benefits occurs.

Response: The bureau has deleted this definition.

Comment: The bureau does not have authority to set standards for a claims office or require that benefits be commenced from a claims office within the state. This definition should be deleted.

Response: The bureau has deleted this definition.

Comment: The proposed rules include very rigid claims handling deadlines that shift the focus of claims handling to compliance with Bureau deadlines and away from timely return to work and claim resolution. According to Bureau data, (1) the median number of weeks from injury to conclusion has dropped from 85 weeks to 38 weeks, (2) the median number of weeks from date of maximum medical improvement to conclusion has dropped from 29 weeks to 13 weeks, and (3) the median number of weeks of temporary total disability benefits has dropped from 21 weeks to 10 weeks. This is very strong evidence of the effectiveness of the Bureau in implementing the 2013 Reform Act. It is also evidence of the effectiveness of adjusting entities in processing claims under the reforms. As outlined below, the proposed micro-management of the claims process will increase administrative expenses in the workers' compensation system and create inefficiencies and new frictions in the claims handling process. There is no apparent systemic problem in the Tennessee workers' compensation system that these proposals cure.

Response: The bureau agrees in part. While the data shows improvement, there are frequent criticisms communicated to the Governor's office and to the TN General Assembly from injured workers of effects on injured workers affected by the 2013 Reform Act. Public Chapter 803 (2016) which passed the House and Senate in a unanimous vote, was the result of the criticism of the adjusting and case management of workers' compensation claims. The intent of this law, codified in T.C.A. § 50-6-419, was to improve case management and adjustment of workers' compensation claims in Tennessee.

Comment: Proposed 0800-2-14-.05 Claims Handling and Investigation... (1) The adjuster shall make verbal or written contact with the employee within two (2) business days of receiving verbal or written notice of any injury, including those considered to be "medical only".
According to NCCI data, approximately 77.5% of Tennessee workers' compensation claims are "medical only". Insurers typically do not receive notice of "medical only" claims until after the injured worker has received medical care and returned to work. This claims handling requirement will increase the cost of adjusting "medical only" claims and unwisely divert claims resources away from the more serious lost time claims. In addition, the 2-day requirement is arbitrary and impractical. Insurers have no control over the delivery of written communications.

Response: The bureau agrees and has amended this rule.

Comment: Proposed 0800-2-14-.05 Claims Handling and Investigation... (2) Adjusters shall make personal or

telephone contact with the employer within two (2) business days of the notice of the injury to verify details regarding the claim. Most claims are reported to insurers by the employer who provides details regarding the claim at the time of reporting. This subsection potentially requires the insurer to duplicate investigation that took place at the time of reporting. For claims not initially reported by the employer, it frequently takes more than two days to identify and contact the appropriate person with the employer to verify claim details.

Response: The bureau disagrees. This is not a duplication of the investigation. It is to verify important facts. And, identifying the appropriate person with the employer should occur when the claim is reported

Comment: Proposed 0800-2-14-.05 Claims Handling and Investigation... (4) In claims when compensability is questioned, adjusters shall contact all authorized medical providers, or their staff members, who have rendered medical services to an employee within three (3) business days of an initial office visit to investigate details concerning the injury and treatment and make a preliminary compensability determination.

This requirement would be arbitrary and impractical in many claims. Compensability may not be questioned by the insurer until more than three days after an initial office visit. In particular, the insurer may not question compensability of the claim or compensability of part of the claim until receipt and review of the medical report from the medical provider which is typically more than three days after the initial visit. To the extent that the medical narrative adequately addresses the compensability issue, additional contact with the medical provider would be unnecessary and not well-received by the medical provider. The insurer may not know the identity of the medical provider selected by the employer until more than three days after the initial office visit. This mandated level of unnecessary contact with medical providers is likely to have an adverse impact on availability of medical providers to handle Tennessee workers' compensation claims because of the unnecessary friction created by the rule.

Response: The bureau disagrees. The rule is regarding "preliminary compensability determination" meaning that it could change during the course of treatment. Three days on an initial determination is not overly burdensome.

Comment: It is suggested that Workers' Compensation Act be changed to Workers' Compensation Law for consistency with T.C.A. §50-6-101, which specifically states, "This chapter shall be cited to as the 'Workers' Compensation Law'..."

Response: The bureau agrees and has deleted references to the "Act".

Comment: In general, suggested consistency between the use of either T.C.A. or T.C.A. as well as if there is a space after the section symbol or not.

Response: The bureau agrees and the changes have been made to T.C.A. and the spacing has been corrected.

Comment: In definitions, (2) "Adjusting entity" means a trade or professional association, managing general agency, pool, third party administrator and/or insurance company licensed to write workers' compensation insurance in Tennessee and shall also mean a self-insured employer or group self-insured employers possessing a valid certificate of authority from the commissioner of commerce and insurance pursuant to T.C.A § 50-6-405. Suggested to add "and for which adjusters and claims handlers act as their representatives in handling workers' compensation claims" to the end of this definition.

Response: The bureau disagrees that the suggestion would add clarity. The term "claims handlers" is not defined by these rules.

Comment: Rule 0800-02-14-.03. General Requirements.
(3) Each adjusting entity shall designate at least one contact person to serve as a liaison between the entity and the Bureau. The designee must have the ability to provide information about claims assignments, status of payments and contact information for the adjusting entity's adjusters as well as the entity's primary EDI contact. The designee's name, title, direct phone number, email address, and mailing address shall be provided to the Bureau, on a form prescribed by the Bureau, in January of each year and within fifteen (15) calendar days of any change regarding the designee for that entity. Each January and July, the designee shall provide the Bureau, on a form prescribed by the Bureau, with the name(s), direct phone number(s), email address(es), and mailing address(es) for each individual adjuster that is performing duties covered by these Rules. Each separate act of not timely notifying the Bureau of a change in the designee or not timely providing the information required in this subsection regarding adjusters shall constitute a separate violation and may subject the entity to assessment of a civil penalty, per Rule 0800-02- 01-.10, for each separate act.
Suggestion the designee and adjuster information be provided once a year in January, instead of providing

adjuster information twice a year, which is burdensome.

Response: The bureau disagrees that twice per year is unduly burdensome. Once per year in January is not sufficient, given the industry's frequent personnel turnover.

Comment: (4) If an adjusting entity contracts with a trading partner to electronically file transactions with the Bureau on the entity's behalf, or uses a trading partner's software product for electronically sending transactions to the Bureau, a Trading Partner Agreement form, provided by the Bureau, must be fully completed and submitted to the Bureau. The adjusting entity shall remain responsible for the timely filing of transactions required by this rule, processing of acknowledgements, and any penalties and fines that may result from untimely electronic filings. Under the proposed Rules, is an Adjusting Entity going to be required to either contract with or use a Trading Partner's software to electronically file transactions with Bureau?

Response: No, there is no such requirement. This rule begins with "If".

Comment: Rule 0800-02-14-.04. Claims Reporting Requirements. (1) All forms required by these rules must be filed with the Bureau via EDI, unless an electronic form equivalent is specifically allowed or required by the Bureau. Requirements for EDI reporting are posted on the Bureau's website.
In terms of a majority of the claims in our office, we handle claims on behalf of clients through an Adjusting Entity representing self-insurance funds created pursuant to Tennessee Law which only write policies in the State of Tennessee. As such, any requirement the Adjusting Entities with whom we work incur the cost associated with the same is unduly burdensome and costly and such costs may be passed down to the insureds, which is far from ideal.
Suggestion that insureds in self-insurance pools created pursuant to Tennessee Law be exempt from this requirement.

Response: Insureds in self-insurance pools are required to file via EDI today, so this is not a new requirement. Trading Partner Agreements may be of assistance and are authorized in the rules.

Comment: (3)(b) An adjusting entity will be subject to a penalty for any calendar month in which it fails to successfully transmit its documents with at least an 85% acceptance by the Bureau success rate for its filings. The assessment of this penalty will not preclude the assessment of additional penalties outlined in Rules 0800-02-13. How will the Bureau's success rate be calculated?

Response: The rate will be the calculation of rejected submissions as a percentage of total EDI submissions.

Comment: (4)(b) Injuries that result in death or a personal injury of a nature that the injured person did not return to the person's employment within seven (7) calendar days after the occurrence of the injury must be reported no later than fourteen (14) calendar days after the report by an employer of the occurrence of the injury.
Person is not a defined term so should read "employee" or "employee."

Response: The bureau agrees and the change has been made.

Comment: (c) Minor injuries such as scratches, scrapes, paper cuts and/or other injuries treated solely by minor first aid are not required to be reported to the Bureau. More serious injuries such as sprains, strains or bruising must be reported. The current Rules 0800-02-01-.06(1) and (2) requires filing a First Report of Work Injury with the Bureau in the event of any injury or illness. Under the proposed Rule, are we correct in reading this will no longer be required if the injury is minor, even if the employee receives medical treatment? Is "minor first aid" the same as minor medical treatment?

Response: The rule attempts to clarify what minor injuries do not require the filing of a First Report of Injury.

Comment: Within two (2) business days of receiving a verbal or written notice of any injury from an employer, the adjusting entity shall send a Notice of a Reported Injury on a form prescribed by the Administrator to each employee's last known address via first class US Mail. The adjusting entity shall also advise the employer of its requirement to provide the employee with a copy of the Beginner's Guide to Tennessee Workers' Compensation. Is the Notice of a Reported Injury a new form or is this the First Report of Work Injury?

Response: The Notice of a Reported Injury is a new form that the Bureau will create that will be mailed to the injured employee by the adjusting entity.

Comment: When does the employer have to provide the Beginner's Guide to Tennessee Workers'

Compensation? Under the proposed Rule 0800-02-01-.05, it is unclear whether the employer is required to provide a employee a Beginner's Guide to Tennessee Workers' Compensation when an injury is reported and/or when an employee is provided a Panel of Physicians? This proposed Rule suggests the employee is to be provided the same when an injury is reported. Suggested that emailing an employee a link to this form from the Bureau's website would also be deemed sufficient as providing the same in paper copy would be time consuming and costly.

Response: The bureau agrees. The claims adjuster may provide the Beginner's Guide. A link to the bureau website will be sufficient.

Comment: Decisions on compensability shall be made by the adjusting entity within fifteen (15) calendar days of the verbal or written notice to employer of injury. If after conducting a reasonable investigation as required by Rule 0800-02-21-.18 a claim is denied, the adjusting entity must notify the Bureau within one (1) business day of reaching that decision by filing the Notice of Denial of Claim for Compensation and must provide the employee or their representative, the treating physician and the insured a non-EDI version of the Notice of Denial, available on the Bureau's website, simultaneously with the notification to the Bureau. The notice must include the basis for the denial. Notice of injury to whom? Employer or Adjusting Entity? Reduces the time for filing of a Notice of Denial and notification to all of the same from 10 days to 1 business day. Perhaps 7 days is more reasonable, especially considering Notice may have to be provided to up to three other persons?

Response: Decisions on compensability are made by the adjuster, so the 15 days starts upon the adjuster's receiving notice. The current requirement is not 10 days, but is "immediately". This rule clarifies when it must be filed.

Comment: Rule 0800-02-14-.05. Claims Handling and Investigation. (2) Adjusters shall make personal or telephone contact with the employer within two (2) business days of the notice of injury to verify details regarding the claim. Insurers and employers shall obtain a description of the job and prior claim information of the employee within five (5) working days. All pertinent witnesses shall be contacted by the insurer as they become known. Notice of injury to whom? Employer or Adjuster? Insurer is not a defined term so what entity besides the employer is to obtain the job description?

Response: The bureau neither agrees nor disagrees with the comment. There is no mention in the rules of obtaining a job description.

Comment: Rule 0800-02-14-.06. Payments of Benefits. (1) Benefits are deemed paid when addressed to the last known address of the worker or beneficiary and deposited in the U.S. Mail or when funds are transferred to a financial institution for deposit in the worker's or beneficiary's account by approved electronic equivalent. Worker is not a defined term so should be employee or employee. Further, in regards to death benefits, suggested it is more appropriate to use the term "dependent" instead of beneficiary as "dependent" is the term used in T.C.A.§ 50-6-210.

Response: The bureau agrees and has made the change.

Comment: All workers' temporary total disability benefits shall be issued accurately and timely to assure the injured employee receives the benefits on or before the date they are due. To help ensure accuracy, Adjusters shall verify the average weekly wage of the employee with the employer consistent with the Bureau's requirements and the requirements of the Act. A Wage Statement, available on the Bureau's website, shall be filed with the Bureau upon request pursuant to Rule 0800-02-21-.10(3).
Worker is not a defined term so should be employee or employee. Suggested consistency in using either employee or employee.

Response: The bureau agrees and the changes have been made.

Comment: All disability and death benefits shall be paid by check or direct deposit unless prior written permission for an alternative means of payment is given by the Administrator and the employee or employee's dependents have signed a written agreement allowing an alternative means. Any instrument of payment must be negotiable and payable to the employee or the employee's dependents for the full amount of the benefit due, without cost to the employee. The employee or employee's estate must be able to make an initial withdrawal of the entire amount of the benefit due, less any appropriate attorney fees, without delay or cost to the worker. The use of the term "estate" is ill advised since the Law requires payments be made to a statutory "dependent(s)" and an estate is only paid death benefits in the event a employee has no dependents. Additionally, it is usually months following a death that an estate is created in the appropriate court.

Response: The bureau agrees and the changes have been made.

Comment: Rule 0800-02-14-.08. Resolution Process. (1) The permanent impairment rating and date of maximum medical improvement determined by the treating physician, and other information needed to settle a claim shall be documented in writing on a form prescribed by the Administrator and provided, at no cost, to the employee within fifteen (15) calendar days of its receipt by the adjuster.
Now requires the employee be provided the authorized treating physician's opinion on maximum medical improvement and medical impairment "on a form prescribed by the Administrator." Does this mean if this information comes in the form of a medical note it does not have to be provided to the employee? If so, can we assume we are only required to provide the employee with a Final Medical Report? Also, what if there is a problem with the medical impairment rating and the adjuster is seeking clarification from the physician? In this case, it would seem inappropriate to be required to send the employee a possibly incorrect medical impairment rating. Please also note it can be weeks or months after an adjuster receives an opinion on maximum medical improvement before the adjuster receives the opinion on medical impairment and/or a Final Medical Report.
(2) Adjusters shall make an offer of settlement in writing within thirty (30) calendar days of receipt of information specified above. If settlement is not agreed upon, a Benefit Review Conference or an Alternative Dispute Resolution, whichever is appropriate, may be requested by either party in accordance with the Bureau's rules. Again, is the "information specified above" a Final Medical Report since it would be a "form prescribed by the Administrator?"

Response: Injured employees are entitled to copies of all of their personal medical records—currently and under the proposed rules. The appropriate form is the current C-30A Final Medical Report.

Comment: Regarding the liaison requirement, there should be some limitation. What triggers it? A PBD? And what ends it? Once the matter goes to court, there could be some overlap in adjudicatory functions and investigative functions.

Response: The liaison requirement is a simple designation of one contact person for an employee, and is not triggered by the filing of a PBD with the bureau.

Comment: Is in-state requirement mandatory? Should there be a grandfathering in mechanism?
As to timelines, they are too stringent. Due to the number of phone calls by adjuster to physicians, there is a lot of additional work for adjusters who are handling 120 claims each.

Response: The in-state claims office requirement is no longer mandatory, per PC 709 (2018). The bureau agrees with the timelines for form filing, and those timelines have been relaxed to be consistent with other states.

Comment: EDI success rate must be 85% or better or be hit with penalty – Not a fan. Too many technical problems could go wrong and shouldn't be made to pay a penalty for it if acting in good faith to fix the problem.

Response: The bureau disagrees. The 85% standard is in keeping with what other states do and was based upon a recommendation from the External Committee of representatives from carriers, employers and TPAs that was organized by the bureau prior to the drafting of these amended rules. Utah has an 85% standard. NY has a 90% standard. Virginia has a 90% goal.

Comment: Pg 4 (5) - 2 Business days to provide notice of 1st report and a copy of the "Beginners Guide to Work Comp". – Not a fan of this. Too little time and too much added paperwork to administer on our end.

Response: The bureau disagrees that two business days is too short a time period to provide this important information.

Comment: Pg 4(6) EDI Denial – we must send a copy of denial to state and another copy to employee within 1 business day or penalty. --- Too little time. Should be no penalty for good faith efforts.

Response: Penalties will be issued on a case-by-case basis, and reasonable, good faith action will be taken into consideration.

Comment: Pg 5(3) We must make written contact with all employees LT to Med Only. – I understand LT but not all Medical only claims should have this requirement. Too burdensome and not necessary.

Response: The bureau agrees in part and the rule has been amended.

Comment: Pg 6 (1) We must provide a C-30A related information to the employee within 15 days or penalty. – Too little time and there should be no penalty for good faith efforts.

Response: Thirty days is the requirement by rule, and this time frame is appropriate.

Comment: Pg 7(2) In all settlement matters regardless of indemnity we must submit and SDF within 30 days. Not a fan. I believe too much burden on claim department to submit overabundance of forms and data to multiple parties.

Response: The bureau disagrees that the form filing requirements are unduly burdensome.

Comment: Notice Rulemaking Hearing Claims Handling Standards 0800-02-14-.04 Paragraph (5) – The two (2) business days requirement is especially onerous. We may not even have been able to make enough contacts to establish compensability by that time. The timeframe requirement should be extended or removed.

Response: The bureau disagrees. It is not required to determine compensability within two days. This contact helps determine compensability.

Comment: Notice Rulemaking Hearing Claims Handling Standards 0800-02-15-.05 Paragraph (1) – The requirement to make contact with the employee should be limited to indemnity claims. It makes very little sense for this to apply to medical-only claims, as doing so would add needless costs to the claims handling process, in addition to lost production if an employee is at work and must stop to take a call from a claims adjuster.

Response: The bureau agrees in part, and the rule has been amended.

Comment: While we understand the intent of regulatory language to provide prompt and appropriate attention to an injured worker, a goal that the industry shares. There are holds concerns that the regulatory language may not be consistent with the best way to make contact between an insured and the worker. As an example, under 0800-2-14-.05 regarding contact within two business days including medical only claims: Would a notice letter outside of the notice of reported injury meet this objective? There is concern that it may be difficult to contact the injured worker to meet the requirement as written. Similar concerns exist for adjusters needing to make personal or telephone contact. Given the context of the situation, the prescribed version of contact may be untenable. It is suggested that the regulation be redrafted to consider a letter as substantial contact in all claims scenarios.

Secondly, we also purport that the regulation may need to contemplate when a case is being litigated, and the impact of that situation on the claims handling and notification procedures. Suggestion that the Bureau mirror the regulatory procedures of claims handling for other P&C lines as it pertains to active litigation.

Response: The rule regarding contact in med only claims has been amended. Regarding cases in litigation, no suggested language was provided as to specific rules to be amended.

Comment: In 0800-02-14-.03(2), please confirm that all TN adjusters do not have to be housed in TN. We have some of our TN staff located in Nashville but we also have a few located in other offices.

Response: All adjusters who adjust TN claims do not have to be in TN. There is no longer a requirement for an in-state claims office. See P.C.0709 (2018)

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rulemaking process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

1. The type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, or directly benefit from the proposed rule: The amended rules should not affect small employers that fall under the Tennessee Workers' Compensation Laws, which would be employers with at least five employees, or for those in the construction industry at least one employee. There should be no additional costs associated with these rule changes.

2. The projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record. There is no additional record keeping requirement or administrative cost associated with these rule changes.

3. A statement of the probable effect on impacted small businesses and consumers: These rules should not have a negative impact on consumers or small businesses.

4. A description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and objectives of the proposed rule that may exist, and to what extent the alternative means might be less burdensome to small business: There are no less burdensome methods to achieve the purposes and objectives of these rules.

5. Comparison of the proposed rule with any federal or state counterparts: None.

6. Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule: Exempting small businesses could frustrate the small business owners' access to the services provided by the Bureau of Workers' Compensation and timely medical treatment for injured workers, which would be counter-productive.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (http://state.tn.us/sos/acts/106/pub/pc1070.pdf) of the 2010 Session of the General Assembly)

These proposed rules will have little, if any, impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

(A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

These rules are amendments to existing claims handling standards of the Bureau of Workers' Compensation concerning procedures for handling workers' compensation claims in Tennessee.

(B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

T.C.A.§ 50-6-419:The bureau's administrator shall set standards by rule governing the adjustment and settlement of workers' compensation claims by any entity acting on behalf of insurance carriers/employers.

(C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

Workers' compensation insurance carriers and employers, including self-insured employers, will be affected by the adoption or rejection of these rules.

(D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

None

(E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars ($500,000), whichever is less;

The overall effect will have little fiscal impact upon state or local government.

(F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Troy Haley, Legislative Liaison and Director of Administrative Legal Services

(G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Troy Haley, Legislative Liaison and Director of Administrative Legal Services

(H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees:

Tennessee Bureau of Workers' Compensation 220 French Landing Drive, Floor 1-B Nashville, TN 37243 (615) 532-0179 troy.haley@tn.gov

(I) Any additional information relevant to the rule proposed for continuation that the committee requests.

None

RULES
OF THE DEPARTMENT OF LABOR
DIVISION OF WORKERS' COMPENSATION

CHAPTER 0800-2-14
CLAIMS HANDLING STANDARDS

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0800-2-14-.01 ~~PURPOSE AND~~ SCOPE OF RULES.

~~(1) Purpose: To assure that employees sustaining an injury arising out of and in the scope of employment are treated fairly and to assure that workers' compensation claims are handled in an appropriate and uniform manner.~~

~~(2) Scope: The provisions of this chapter shall apply to all employers in the State of Tennessee subject to provisions of the Workers' Compensation Law.~~

The provisions of this chapter shall apply to all employers, adjusting entities and providers of services related to workers' compensation claims in the State of Tennessee subject to ~~the~~ provisions of the Workers' Compensation Law~~Act~~.

Authority: *TCA §50-6-419.* ***Administrative History:*** *Original rule filed on December 15, 1997; effective February 28, 1998.*

0800-2-14.02 DEFINITIONS.

~~(1)"Act" means Tennessee Code Annotated, Title 50, Chapter 6the applicable Workers' Compensation Law in effect.~~

(1) ~~"Insurer" or claims handler means self-insured employer, trade or professional association, third party administrator and/or insurance company.~~ "Adjusting entity" means a trade or professional association, managing general agency, pool, third party administrator and/or insurance company licensed to write workers' compensation insurance in Tennessee and shall also mean a self-insured employer or group self-insured employers possessing a valid certificate of authority from the commissioner of commerce and insurance pursuant to T.C.A §50-6-405.

(2) ~~(3)~~"Adjuster", "claims adjuster", "med-only adjuster", or "claims handler" means a representative of an adjusting entity who investigates workers' compensation claims for the purposes of making compensability determinations, files or causes claims forms to be filed with the Bureau, commences benefits, and/or makes settlement recommendations based on the insured's liability on behalf of a self-insured employer, trade or professional association, third party administrator, and/or insurance company.

(3) ~~"Insured" or employer means any individual, firm, association or corporation, or the receiver, or trustee of the same, or the legal representative of a deceased employer, using the services of not less than five (5) persons for pay, except as provided in TCA §50-6-113 dealing with subcontractors and those engaged in the construction industry, and in the case of an employer engaged in the mining and production of coal, one (a) employee for pay. If the employer is insured, it shall include the employer's insurer, unless otherwise herein provided.~~ "Administrator" shall have the same definition of "Administrator" as in T.C.A §50-6-102.

~~(4) "Employee" includes every person, including a minor, whether lawfully or unlawfully employed, the president, any vice-president, secretary, treasurer or other executive officer of a corporate employer without regard to the nature of the duties of such corporate officials, in the service of an employer, as employer is defined in (3) above, under any contract of hire or apprenticeship, written or implied. Any~~

reference herein to an employee who has been injured shall, where the employee is dead, also include such employee's legal representatives, dependents and other persons to whom compensation may be payable under the Workers' Compensation Law;

"Employee" also includes a sole proprietor or a partner, who devotes full time to the proprietorship or partnership and elects to be included in the definition of employee by filing written notice thereof with the Division of Workers' Compensation at least thirty (30) days before the occurrence of any injury or death, and may at any time withdraw the acceptance by giving notice of the withdrawal to the division.

(5) "Claimant" means an employee who alleges an injury or occupational disease sustained in the course and scope of employment.

(4) "Bureau" means the Tennessee Bureau of Workers' Compensation as defined in Tenn. Code Ann. § 50-6-102, an autonomous unit attached to the Department of Labor and Workforce Development for administrative matters only, pursuant to Tenn. Code Ann. § 4-3-1409.

(Rules 0800-2-14-.02, continued)

(5) "Director" means the Director of the Division of Workers' Compensation or the appointed agent of such Director. "Claim" means a demand for something as due; an assertion of a right or an alleged right.

(6)

"Division" means the Workers' Compensation Division of the Tennessee Department of Labor. "Claimant" means an individual who is claiming benefits under the Act.

(6) "Electronic Data Interchange" or "EDI" means the electronic communication method that provides standards for exchanging data via electronic means. The term "EDI" encompasses the entire electronic data interchange process, including the transmission, message flow, document format, and software used to interpret the documents using the standards established by the IAIABC and the Release Version accepted by the Bureau at the time of the filing.

(7) "Electronic Form Equivalent" means the original document, provided on the Bureau's website, which is to be used when a sender reports required data via a paper document. When forms are reproduced, they shall be reproduced in their entirety, including instructions and shall not be modified without written consent of the Administrator. A form may be revised at any time at the discretion of the Administrator and will be available at no cost.

(8) "Employee" shall have the same definition of "Employee" as in T.C.A §50-6-102;

(9) "Employer" shall have the same definition of "Employer" as in T.C.A §50-6-102.

(10) "First Report of Work Injury" means the EDI equivalent of the form available on the Bureau's website and designated by the Bureau as the appropriate document to initially report a claim of injury.

(11) "Form" means the document as is available on the Bureau's website on the date of the filing.

(12) "IAIABC" means the International Association of Industrial Accident Boards and Commissions.

(13) "Injury" and "personal injury" shall have the same definition of "injury" as in T.C.A §50-6-102.

(14) "Insured" shall have the same definition of "Employer" as in T.C.A §50-6-102.

(15) "Medical-only" claim or "med-only" claim means a claim requiring medical attention, but which has no indemnity benefits due or paid. Any claim in which no indemnity benefits are due or paid, but which has medical treatment provided by any medical personnel qualifies the claim for medical only status, regardless of whether or not a bill is generated and regardless of whom pays for the medical care.

(16) "Trading partner" means an entity approved by the Bureau to exchange data electronically with the Bureau on behalf of an adjusting entity.

(7)

(8) "Injury" means an injury by accident arising out of and in the course of employment which causes either disablement or death of the employee and shall include occupational diseases arising out of and in the course of employment which cause either disablement or death of the employee.

Authority: *TCA §§50-6-102 and 50-6-113.* ***Administrative History:*** *Original rule filed on December 15, 1997; effective February 28, 1998.*

0800-2-14-.03 GENERALREPORTING REQUIREMENTS.

(1) In order to ensure that Workers' Compensation claims are acted on promptly, employers shall report verbally or in writing all known or reported accidents to their insurer within one working day of knowledge of injury.

(2) Every insurer shall file with the Division a report of accident on Form C-20 (Tennessee Employer's First Report of Work Injury) pursuant to Rule 0800-2-1-.06. Effective January 1, 1998, Form C-20 shall require the signature of the injured employee. If the injured employee is unable to sign the form or refuses to sign the form, an explanation shall be required.

(1) A wage statement to insure the correct rate of compensation shall be filed with the Division and shall accompany the Form C-22 (Notice of First Payment of Compensation) or Form C-23 (Notice of Denial of Benefits). Filings shall be made pursuant to Rule 0800-2-1-.07. Any employer or adjusting entity that knowingly, willfully and intentionally causes a claim to be paid under any health or sickness and accident insurance or that fails to provide reasonable and necessary medical treatment, including a failure to reimburse when the employer or adjusting entity knew that the claim arose out of a compensable work-related injury shall be assessed a civil penalty of $500.00. The employer or adjusting entity shall not offset any benefit paid by that insurance against its temporary total disability benefit liability.

(2) Each adjusting entity shall designate at least one contact person to serve as a liaison between the entity

and the Bureau. The designee must have the ability to provide information about claims assignments, status of payments and contact information for the adjusting entity's adjusters as well as the entity's primary EDI contact. The designee's name, title, direct phone number, email address, and mailing address shall be provided to the Bureau, on a form prescribed by the Bureau, in January of each year and within fifteen (15) calendar days of any change regarding the designee for that entity. Each January and July, the designee shall provide the Bureau, on a form prescribed by the Bureau, with the name(s), direct phone number(s), email address(es), and mailing address(es) for each individual adjuster that is performing duties covered by these Rules. Each separate act of not timely notifying the Bureau of a change in the designee or not timely providing the information required in this subsection regarding adjusters shall constitute a separate violation and may subject the entity to assessment of a civil penalty, per Rule 0800-02-01-.10, for each separate act.

(3) If an adjusting entity contracts with a trading partner to electronically file transactions with the Bureau on the entity's behalf, or uses a trading partner's software product for electronically sending transactions to the Bureau, a Trading Partner Agreement form, provided by the Bureau, must be fully completed and submitted to the Bureau. The adjusting entity shall remain responsible for the timely filing of transactions required by this rule, processing of acknowledgements, and any penalties and fines that may result from untimely electronic filings.

(4) All adjusting entities or trading partners shall utilize anti-virus software to remove any viruses on all electronic transmissions prior to sending electronic transmissions to the Bureau. The adjusting entity or trading partner shall maintain the anti-virus software with the most recent anti-virus update files from the software provider. If the adjusting entity or trading partner sends a transmission that contains a virus which prevents the Bureau from processing the transmission, the transmission will not be considered as having been received.

Authority: *TCA §50-6-419 and 50-3-702.* ***Administrative History:*** *Original rule filed on December 15, 1997; effective February 28, 1998.*

0800-2-14-.04 ~~INVESTIGATION.~~Claims Reporting Requirements

~~(1) Upon verbal or written notice of any injury from an employer, the insurer shall make verbal or written contact with the claimant within two (2) working days to confirm facts of the claim, history of prior claims, work history, wages, and job duties. This may include a recorded statement.~~

~~(2) Insurers shall make personal or telephone contact with the employer within two (2) working days of notice of accident to verify accident details. Insurers and employers shall obtain a description of the job and prior claim information of the claimant within five (5) working days. All pertinent witnesses shall be contacted by the insurer as they become known.~~

~~(3) Insurers shall verify the average weekly wage of the claimant consistent with the Division's requirements and the requirements of TCA §50-6-205.~~

~~(4) Insurers shall contact physicians who have rendered medical services to a claimant within seventy-two (72) hours of verbal or written notice to confirm injury and treatment and make preliminary compensatory determination.~~

~~(5) All aspects of contacting and attempts to contact insureds, the claimant and physicians shall be documented within the insurer's file.~~

~~(6) When third party subrogation recovery is appropriate, insurers shall develop a strategy to promptly obtain needed evidence.~~

~~(7) Decisions on workers' compensation insurance coverage and compensability shall be made within fifteen (15) days of verbal or written notice of accident. All pertinent documents of the Division of~~

(Rules 0800-2-14-.04, continued)

~~Workers' Compensation shall be filed within fifteen (15) days of verbal or written notice of accident. Claimants and employers shall be notified of the decision of compensability within fifteen (15) days of verbal or written notice of accident.~~

~~(8) Denial of a claim shall be supported with documented results of the investigation. Form C-23 (Notice of Denial) shall be filed with the Division within ten (10) days of denial and a copy of Form C-23 shall be provided to the claimant within the same time frame.~~

~~(9)If an insurer denies a claim, the insurer shall provide documentation which meets the statutory criteria for denial on Form C-23 upon request by the Division, employer, claimant, and/or their legal representatives.~~

(1) All forms required by these rules must be filed with the Bureau via EDI, unless an electronic form equivalent is specifically allowed or required by the Bureau. Requirements for EDI reporting are posted on the Bureau's website.

(2) The adjuster, when required, shall include the following information on every form it submits to the Bureau:

a. The employee's name.
b. The employee's date of birth.
c. The month, day, and year of the employee's injury or illness, in the following order: mm-dd-yy or mm-dd-yyyy.
d. The employee's social security number (SSN) as assigned by the Social Security Administration.
   i. If the employee does not have a SSN, the adjusting entity shall assign an identification number that begins with the number "9" and is followed by the employee's date of birth, in the following format 9MMDDYYYY.
   ii. If the adjusting entity later learns the correct SSN, the adjusting entity shall immediately notify the Bureau via EDI by filing the appropriate FROI Change of SSN notice.

(3) The adjusting entity shall ensure that all documents filed with the Bureau pursuant to this chapter, either by EDI or electronic form ~~paper~~ equivalent, are complete and legible.

a. If a filing is not complete and error free, the filing shall be rejected. The adjusting entity shall make the correction, and resubmit the filing to the Bureau. The filing will be considered "accepted" and in compliance with this section only when a complete and error free filing is received and not rejected by the Bureau.
b. An adjusting entity will be subject to a penalty for any calendar month in which it fails to successfully transmit its documents with at least an 85% acceptance by the Bureau success rate for its filings. The assessment of this penalty will not preclude the assessment of additional penalties outlined in Rules 0800-02-13.

(4) Every adjusting entity shall submit Tennessee's First Report of Work Injury form to the Bureau as soon as possible in all cases where the reported injury results in the need for medical treatment, restricted work, the inability to work, or death, but no later than the time frames listed below.

a. Reports of all injuries causing seven (7) calendar days of disability or fewer shall be submitted on or before the fifteenth (15th) day of the month following the month in which the injury occurred.
b. Injuries that result in death or a personal injury of a nature that the injured employee ~~person~~ did not return to the ~~person~~employee's employment within seven (7) calendar days after the occurrence of the injury must be reported no later than fourteen (14) calendar days after the report by an employer of the occurrence of the injury.
c. Minor injuries such as scratches, scrapes, paper cuts and/or other injuries treated solely by minor first aid are not required to be reported to the Bureau. More serious injuries such as sprains, strains or bruising must be reported.

(5) Within two (2) business days of receiving a verbal or written notice of any injury from an employer, the adjusting entity shall send a Notice of a Reported Injury and a copy of the Beginner's Guide to Tennessee Workers' Compensation -on athe -forms prescribed by the Administrator to each

(Rules 0800-2-14-.04, continued)

~~claimant~~employee's last known address via first class US Mail. ~~The adjusting entity shall also advise the employer of its requirement to provide the employee with a copy of the Beginner's Guide to Tennessee Workers' Compensation.~~

(6) Decisions on compensability shall be made by the adjusting entity within fifteen (15) calendar days of the verbal or written notice of injury. If after conducting a reasonable investigation as required by these rules ~~Rule 0800-02-21-.18~~ a claim is denied, the adjusting entity must notify the Bureau within five (5) ~~one (1)~~ business days of reaching that decision by filing the Notice of Denial of Claim for Compensation and must provide the ~~claimant~~employee or their representative, the treating physician and the insured a non-EDI version of the Notice of Denial, available on the Bureau's website, simultaneously with the notification to the Bureau. The notice must include the basis for the denial.

(7) Adjusting entities must file the First Report of Payment of Compensation with the Bureau within five (5) business days of the initial payment of benefits and shall submit the Notice of Change or Termination of Compensation Benefits within five (5) ~~one (1)~~ business days of a change or termination of the payment of compensation benefits. The adjusting entity must also provide the ~~claimant~~ employee or their representative and the insured a non-EDI version of the Notice of Change or Termination of Compensation Benefits simultaneously with the notification to the Bureau and must provide the explanation of the rationale upon which the changes were based.

(8) An adjusting entity electing to controvert its liability and terminate the payment of compensation benefits after temporary disability and/or medical benefits have been paid in a claim, shall submit a Notice of Controversy to the Bureau within fifteen (15) calendar days of the due date of the first omitted payment.

Authority: *TCA §§50-6-205 and 50-6-419.* ***Administrative History:*** *Original rule filed on December 15, 1997; effective February 28, 1998.*

0800-2-14-.05 ~~PAYMENTS OF BENEFITS.~~Claims Handling and Investigation

~~(1) Compensation payments for an injury shall be received by the claimant no later than fifteen (15) days after notice of injury.~~

~~(2)~~(1) ~~All workers' compensation benefits shall be issued timely to assure the injured employee receives the benefits on or before the date they are due.~~

(1) The adjuster shall make verbal or written contact with the employee ~~claimant~~ within two (2) business days of receiving a verbal or written notice of any injury, including those considered to be "medical-only". For "medical-only" claims, ~~T~~this contact is ~~not~~ satisfied by the mailing of the Notice of a Reported Injury referenced herein. In claims that involve lost time from work, this contact is not satisfied by the mailing of the Notice of a Reported Injury referenced herein. The purpose of this contact is to:

a. Provide each employee ~~claimant~~ with the adjuster's name and contact information, which shall include the adjuster's direct phone number, fax number, email address, and mailing address; and,

b. ~~In claims that involve time lost from work, i~~Investigate the facts of the claim and obtain a history of prior claims, including work history, wages, and job duties.

(2) Adjusters shall make personal or telephone contact with the employer within two (2) business days of the notice of the injury to verify details regarding the claim.

(3) An adjuster assigned to a claim which had previously been assigned to a different adjuster shall make verbal or written contact with the employee ~~claimant~~ within two (2) business days of the assignment and shall provide the employee ~~claimant~~ with the newly assigned adjuster's name and contact information, which shall include that adjuster's direct phone number, fax number, email address, and mailing address. In instances involving a mass transfer of files, such as might occur if an adjusting entity purchased or merged with another adjusting entity, the time required to provide this notice will be extended to seven (7) business days.

(4) In claims when compensability is questioned, adjusters shall contact all authorized medical providers, or their staff members, who have rendered medical services to an employee ~~claimant~~ within three (3) business days of an initial office

(Rules 0800-2-14-.04, continued)

visit to investigate details concerning the injury and treatment and make a preliminary compensability determination.

(5) All employers, adjusting entities and providers of services related to workers compensation claims in the State of Tennessee subject to provisions of the Workers' Compensation ~~Act~~Law shall provide the Bureau all information and documentation that is requested, and only that information that is requested, for the purposes of monitoring, examining, or investigating the entity's operations and processes within ten (10) calendar days unless the Bureau allows an extension of time.

Authority: *TCA §50-6-419.* ***Administrative History:*** *Original rule filed on December 15, 1997; effective February 28, 1998.*

0800-2-14-.06 Payment of Benefits~~RESOLUTION PROCESS.~~

~~(1) A medical impairment rating and date of maximum medical improvement by the treating physician, and information needed to settle a claim shall be documented in writing.~~

~~(2) Insurers shall make an offer of settlement in writing within thirty (30) days of receipt of information specified above,Rule 0800-2-14-.06(a). The claimant shall sign the offer of settlement indicating approval or rejection of the offer.~~

~~(3) An agreed settlement shall be finalized by order of a court or approval by the Division as required by TCA §50-6-206. A copy of the court order or division approval shall be filed with the Commissioner of Tennessee Department of Labor.~~

~~(4)~~(1) ~~If settlement is not agreed upon, a Benefit Review Conference may be requested pursuant to TCA §50-6-237.~~

(1) Benefits are deemed paid when addressed to the last known address of the employee~~worker~~ or dependent ~~beneficiary~~ and deposited in the U.S. Mail or when funds are transferred to a financial institution for deposit in the ~~worker~~employee's or ~~beneficiary~~dependent's account by approved electronic equivalent.

(2) All workers' temporary total disability benefits shall be issued accurately and timely to assure the injured employee receives the benefits on or before the date they are due. To help ensure accuracy, Adjusters shall verify the average weekly wage of the employee ~~claimant~~ with the employer consistent with the Bureau's requirements and the requirements of the Workers' Compensation Law~~Act~~. A Wage Statement, available on the Bureau's website, shall be filed with the Bureau upon request pursuant to Rule 0800-02-21-.10(3).

a. To be considered timely, initial temporary total disability payments must be paid to the ~~claimant~~employee no later than fifteen (15) calendar days after the date the disability begins and every subsequent payment is made within consecutive fifteen (15) calendar day increments, until all temporary total benefits have been paid. Each payment must indicate the time period covered by the payment.

(3) All temporary partial disability benefits shall be issued timely, as per T.C.A §50-6-207(2).

(4) Funeral expenses, including burial or cremation expenses, must be paid within a reasonable period of time, not to exceed thirty (30) days from the date of submission of invoice.

(5) All disability and death benefits shall be paid by check or direct deposit unless prior written permission for an alternative means of payment is given by the Administrator and the employee or employee's dependents ~~claimant or claimant's estate~~ haves signed a written agreement allowing an alternative means. ~~Any instrument of payment must be negotiable and payable to the claimant or the claimant's estate for the full amount of the benefit due, without cost to the claimant. The claimant or claimant's estate must be able to make an initial withdrawal of the entire amount of the benefit due, less any appropriate attorney fees, without delay or cost to the worker.~~

Authority: *TCA §§50-6-237, and 50-6-419.* ***Administrative History:*** *Original rule filed on December*

(Rules 0800-2-14-.04, continued)
15, 1997; effective February 28, 1998.

0800-2-14.07 MEDICAL COSTS.

(1) All medical costs owed under the Tennessee Workers' Compensation Law shall be paid ~~within forty-five (45) days of receipt of bill or invoice. Also within forty-five (45) days, if additional documentation is required for payment, the party requesting payment shall be informed of the needed information. There is no obligation to make payment until adequate documentation is received.~~ pursuant to the Medical Fee Schedule contained in Rules 0800-2-17, 0800-2-18 and 0800-2-19.

~~(2) Medical invoices shall contain the following characteristics:~~

~~(a) CPT (Procedure) Code~~

~~(b) ICD 9 (Diagnostic) Code~~

(Rules 0800-2-14-.07, continued)

~~(3) Remuneration inquiries shall be made directly to the insurer.~~

Authority: *TCA §50-6-419.* ***Administrative History:*** *Original rule filed on December 15, 1997; effective February 28, 1998.*

0800-2-14-.08 ~~ENFORCEMENT.~~Resolution Process

(1) ~~In addition to other penalties provided by applicable law and regulation, violations of any of the above rules shall be subject to enforcement by Commissioner of the Tennessee Department of Labor pursuant to TCA §50-6-419(c).~~ The permanent impairment rating and date of maximum medical improvement determined by the treating physician, and other information needed to settle a claim shall be documented in writing on a form prescribed by the Administrator and provided, at no cost, to the employee~~claimant~~ within thirty (30) ~~fifteen (15)~~ calendar days of its receipt by the adjuster.

(2) Adjusters shall make an offer of settlement in writing within thirty (30) calendar days of receipt of information specified above. If settlement is not agreed upon, a Benefit Review Conference or an Alternative Dispute Resolution, whichever is appropriate, may be requested by either party in accordance with the Bureau's rules.

(3) All settlements shall be reduced to writing and shall be finalized by order or approval of an appropriate court, as required by the Workers' Compensation Law~~Act~~. A copy of the court order or Bureau approval and appropriate Statistical Data Form shall be filed timely with the Bureau.

Authority: *TCA §50-6-419.* ***Administrative History:*** *Original rule filed on December 15, 1997; effective February 28, 1998.*

0800-2-14-.09 ~~FRAUD.~~Claims Resolution Filing Requirements

(1) ~~All provisions regarding the detecting, prosecuting, and/or preventing of workers' compensation fraud shall be governed by TCA §50-6-127 and Title 56, Chapter 47.~~ The appropriate resolution form must be submitted to the Bureau in all claims when they are resolved.

a. In matters concluded by settlement or resolved by trial, the employer or the employer's agent must file a fully-completed appropriate version of the Statistical Data Form contemporaneously with the filing of the final order or settlement.

i. To be considered fully complete, the form must contain all required data, as determined by the Bureau, and reflect information that is current as of the date the information is submitted to the court for approval, whether or not an appeal of the matter is anticipated or filed.

ii. The employee~~claimant~~ and any agent of the employee~~claimant~~ must cooperate with the adjusting entities in completing the statistical data form.

b. In matters not concluded by settlement or resolved by trial, adjusting entities must submit a fully-completed Final Report of Payment and Receipt of Compensation via EDI within thirty (30) days following the final payment of compensation. The form must report all compensation benefits paid on a claim, including all medical expenses (including in-patient, out-patient, pharmacy, case management, therapy, etc.), death benefits and funeral expenses, and legal costs.

(2) A fully-completed Statistical Data Form is also required for every workers' compensation matter even if the only issue resolved is the closing of future medical benefits that had remained open pursuant to a prior order. This requirement applies even if a statistical data form was filed at the time of submission of the prior order.

(3) Pursuant to T.C.A. §50-6-244, an order of the court is not final until the Statistical Data Form has been completed and filed with the appropriate clerk of the court or Bureau office.

(4) If the Administrator or the Administrator's designee determines that an employer or the employer's agent fails to fully complete or timely file the statistical data form, the bureau may assess a civil penalty against

(Rules 0800-2-14-.07, continued)

the offending party not to exceed one hundred dollars ($100) per violation. A party assessed a penalty by the Administrator pursuant to this subsection may appeal the penalty by requesting a contested case hearing pursuant to Rule 0800-02-.13.

Authority: *TCA §50-6-419.* ***Administrative History:*** *Original rule filed on December 15, 1997; effective February 28, 1998.*

0800-2-14-.10 Enforcement

(1) The Bureau has the authority to monitor and audit the performance of adjusters and adjusting entities to ensure compliance with the Workers' Compensation Law~~Act~~ and Bureau Rules as often as it deems necessary which includes, but is not limited to, the review of the following:

a. Ongoing review of data provided to the Bureau by adjusting entities;

b. Timeliness, completeness and accuracy of all filings with the Bureau in any format;

c. Timeliness and accuracy of indemnity and/or payments to medical providers;

d. Denied claims;

e. Timeliness and accuracy of the provision of a panel of physicians;

f. The alleged or suspected harassment, coercion or intimidation of any party;

g. Timeliness of the response to a Request for Assistance, Petition for Benefits Determination or any equivalent form;

h. Timeliness of the compliance with an Order from a Judge of the Court of Workers' Compensation Claims or Workers' Compensation Appeals Board, a Workers' Compensation Specialist, Administrative Law Judge, or an Administrator's Designee;

i. Claims-handling practices;

j. Timeliness of authorizing medical treatment and medications;

k. Mailing of the Notice of a Reported Injury;

l. Mailing of the Notice of Employer Rights and Responsibilities in a Workers' Compensation Claim required by Rule 0800-02-01 to the employer.

(2) Reports resulting from the Bureau's monitoring, examination or investigation conducted under this Chapter are considered public records and may be shared in any means deemed appropriate by the Bureau and may include publicizing those adjusting entities that exceed or fail to meet the Bureau's established thresholds for claims handling excellence.

(3) In addition to other penalties provided by applicable law and regulation, violations of any of the above rules shall be subject to enforcement by the Administrator pursuant to TCA §50-6-419(c).

Authority: TCA §50-6-233, 50-6-415 and 50-6-419. Administrative History: Original rule filed on December 15, 1997; effective February 28, 1998.

0800-2-14-.11 Fraud

All provisions regarding the detecting, prosecuting, and/or preventing of workers' compensation fraud shall be governed by TCA §50-6-127 and Title 56, Chapter 47.

(Rules 0800-2-14-.07, continued)

Authority: TCA §50-6-127, 50-6-419 and 56-47-103. Administrative History: Original rule filed on December 15, 1997; effective February28, 1998.