Arizona

Note: Arizona is a regulated state[1]; however, no URA license, filing or contract is required. Arizona recognizes, but does not require, accreditation.

I. Scope and Applicability

A. State regulations related to workers' compensation and/or utilization review.

- Arizona Annotated Revised Statutes, Title 20 Insurance, Chapter 15 Utilization Review, Article 1 General Provisions (A.R.S. § 20-2501 - § 20-2511)
- Arizona Administrative Regulations, Title 20 Commerce, Financial Institutions and Insurance, Chapter 5 Industrial Commission of Arizona, Article 13 Treatment Guidelines (A.A.C. § R20-5-1301 -§ R20-5-1312)
- Arizona Department of Insurance Website: Utilization Review Agent

B. What activities or processes are regulated by the state as it relates to workers' compensation utilization management?

- Accreditation Recognition
- Clinical Review Criteria Requirements
- State Adopted Guidelines
- Reviewer Qualification Requirements
- Same State Licensure Requirements (includes exception)
- Telephone Access Standards
- Reconsideration Requirements

C. Who is subject to the state's utilization review laws?

Pursuant to A.R.S. § 20-2502(A), a utilization review agent shall not conduct utilization review in this state unless the utilization review agent meets or is exempt from the provisions of this article.

Utilization review for worker's compensation is exempt from the provisions of A.R.S. § 20-2502. See below.

D. What exemptions are provided, if any?

Pursuant to A.R.S. § 20-2502(B)(1-4), a person is exempt from the provisions of this article if the person:

1. Is accredited by the utilization review accreditation commission, the national committee for quality assurance or any other nationally recognized accreditation process recognized by the director.
2. Conducts internal utilization review for hospitals, home health agencies, clinics, private offices or other health facilities or entities if the review does not result in the approval or denial of payment for hospital or medical services.
3. Conducts utilization review activities exclusively for work related injuries and illnesses covered under the workers' compensation laws in title 23.
4. Conducts utilization review activities exclusively for a self-funded or self-insured employee benefit plan if the regulation of that plan is preempted by section 514(b) of the employee retirement income security act of 1974, 29 United States Code section 1144(b).

E. What term does the state use to refer to regulated entities?

Pursuant to Page 100, A.A.C. § R20-5-1302, "Contractor" means an independent peer review organization accredited by URAC.

Pursuant to Page 102, A.A.C. § R20-5-1311, the Commission may enter into an agreement with one or more contractors, who shall be URAC accredited, to provide the review described in subsection (D).

F. What activities does the state include in its definition of utilization review?

Pursuant to Page 100, A.A.C. § R20-5-1302, "Peer Review" means an independent medical review conducted by an individual meeting the requirements of Page 103, R20-5-1311(I).

Pursuant to Page 103, A.A.C. § R20-5-1311(D), the administrative review conducted under this Section shall apply the guidelines as described in this Article and include a peer review performed by an individual meeting the requirements of subsection (I). The peer review shall consist of a records review and, when possible as described in subsection (I)(5), a conversation between the provider and individual conducting the peer review.

Pursuant to Page 100, A.A.C. § R20-5-1302, "Administrative Review" means a process that includes a peer review for preauthorization of a request for medical treatment or services that has been denied or partially denied by a payer. The administrative review process will be managed by the Medical Resource Office (MRO) at the Industrial Commission of Arizona.

Pursuant to Page 100, A.A.C. § R20-5-1302, "Preauthorization" means a request from a provider to a payer requesting approval to

[1] There are state regulations governing at least one aspect of the WCUM process (e.g., state adopted guidelines, required forms, etc.)

provide medical treatment or services to an injured employee.
Pursuant to Page 100, A.A.C. § R20-5-1302, "Reconsideration" means a written request to the payer or identified review organization by an injured employee or medical provider to reconsider a previous payer decision to deny medical treatment or services and that identifies the specific justification to support the request.

II. Regulatory Information

A. Responsible state agency.
Department of Insurance, Industrial Commission of Arizona

B. Contact Information.
Jackie Kurth
Manager of Medical Resources
Resources Office, Industrial Commission
602-542-6731
800 W Washington St
Phoenix, AZ 85007
mro@azica.gov
https://insurance.az.gov/contact-us

I. Licensure/Certification Requirements

A. What entities are required to obtain a license in the state to conduct utilization review for residents of the state?
Entities who perform workers' compensation utilization review are exempt from licensure requirements, however, a UR company may contract with the Industrial Commission of Arizona and must comply with the requirements of Page 99, A.A.C. § R20-5-1301, et seq.

B. How often must licensure be renewed?
Not applicable.

C. Licensure fees (initial and renewal).
Not applicable.

D. Documentation required for licensure.
Not applicable.

E. Exemptions from licensure.
Not applicable.

F. Does the state recognize URAC accreditation?
Yes

G. Which of the state's requirements are waived for URAC-accredited organizations?
Pursuant to A.R.S. § 20-2502(B)(1-4), a person is exempt from the provisions of this article related to Health UR if the person:
1. Is accredited by the utilization review accreditation commission, the national committee for quality assurance or any other nationally recognized accreditation process recognized by the director.

IV. Program Requirements

A. Clinical review criteria.
The Industrial Commission of Arizona (Commission) has adopted the Work Loss Data Institute's Official Disability Guidelines (ODG) as the standard reference for evidence-based medicine within the context of Arizona's workers' compensation system. By adopting and referencing the most recent edition (at the time of treatment), and continuously updated Official Disability Guidelines, the Commission can ensure the latest available medical evidence is used in making medical treatment decisions for injured workers. The use of ODG for the management of chronic pain and the use of opioids for all stages of pain management went into effect on October 1, 2016.
https://www.azica.gov/official-disability-guidelines
Pursuant to Page 100, A.A.C. § R20-5-1302, "Treatment Guidelines" or "guidelines" means medical treatment guidelines that are used as a tool to support clinical decision making and quality health care delivery to injured employees.

B. Adopted Guidelines
Official Disability Guidelines.
Legislation/Rule: HB2368 2012
http://www.odg-twc.com/index.html

C. Prohibitions against financial incentives.
No provision.

D. Telephone access standards.
Pursuant to Page 103, A.A.C. § R20-5-1311(I), the individual conducting the peer review shall:
5. Make a good faith effort to contact the provider requesting the preauthorization. This good faith effort shall include making telephone contact during the provider's normal business hours and offering to schedule the peer review at a time convenient for the provider.

E. Quality assurance program.
No provision.

F. Delegation of utilization review function.
No provision.

G. Confidentiality.
No provision.

H. Required Forms
Forms pertaining to Workers' Compensation:
https://www.azica.gov/forms

V. Reviewer Qualifications

A. Qualifications of reviewers that render utilization review determinations (at each level of utilization review, if applicable).
Pursuant to Page 103, A.A.C. § R20-5-1311(I), the individual conducting the peer review shall:

1. Hold an active, unrestricted license or certification to practice medicine or a health profession and be involved in the active practice of medicine or a health profession during the five preceding years. For purposes of this subsection, "active practice" means performing patient care for a minimum of eight hours per week in one of the five preceding years;
3. For a review of a request from an allopathic or osteopathic physician, nurse practitioner, physician assistant, or other mid-level provider, hold a current certification from the American Board of Medical Specialties or the American Osteopathic Association in the area or areas appropriate to the condition, procedure or treatment under review;
4. Be in the same profession and the same specialty or subspecialty as typically performs or prescribes the medical procedure or treatment requested;

B. Requirements for medical director.
No provision.

C. Requirement for "same-state" licensure.
Pursuant to Page 103, A.A.C. § R20-5-1311(I), the individual conducting the peer review shall:
Be licensed in Arizona, unless the Commission or its contractor is unable to find such an individual, in which case the peer review may be conducted by an individual who is licensed in another state of the United States and who meets the other requirements of this subsection;

VI. Reviews and Appeals

A. Review determinations and notice to patients/providers.

Preauthorization.
Pursuant to Page 101, A.A.C. § R20-5-1309(A), except as provided in subsection (D), a payer shall communicate to the provider its decision on a request for preauthorization no later than 10 business days after the request is received. This decision shall comply with the requirements set forth in subsection (H). For purposes of this Section, the 10 business days begin to run the day after the payer receives the request.
(B) If a payer fails to communicate to a provider its decision on request for preauthorization within 10 business days, then the payer's failure to take action is deemed a "no response" and the provider or injured employee may submit a request for administrative review directly to the Commission as provided in R20-5-1311, Page 102.
(C) If a payer receives a request for preauthorization that fails to meet the requirements of Page 100, R20-5-1303, the payer may, in its discretion:
1. Act on the incomplete request for preauthorization; or
2. No later than 10 business days after the request is received, notify the provider that the request for preauthorization is incomplete.
(D) If, no later than 10 business days after a request for preauthorization has been received, a payer provides notice to the provider that an IME has been requested under Page 12, R20-5-114, then the payer's decision on a request for preauthorization shall be issued no later than 10 business days after the final IME report has been received by the payer. The payer shall provide a copy of the final IME report to the provider upon receipt of the IME report.
Pursuant to Page 102, A.A.C. § R20-5-1309(I), a payer shall provide a copy of its written decision to deny treatment or services to the injured employee.

Administrative Review by Commission.
Pursuant to Page 103, A.A.C. § R20-5-1311,
C. Upon receipt of a request for administrative review, the Commission shall determine whether the administrative review is available under this Article.
1. If administrative review is not available, then no later than three business days after receiving a request for administrative review, the Commission shall send notice to the injured employee and payer that administrative review is not available.
2. If administrative review is available, then no later than three business days after receiving the request, the Commission shall send notice to the payer that a request for administrative review has been received and provide information on how to participate in the process.
D. The administrative review conducted under this Section shall apply the guidelines as described in this Article and include a peer review performed by an individual meeting the requirements of subsection (I). The peer review shall consist of a records review and, when possible as described in subsection (I)(5), a conversation between the provider and individual conducting the peer review.
E. The Commission may enter into an agreement with one or more contractors, who shall be URAC accredited, to provide the review described in subsection (D).
G. To assist in its review, the Commission or its contractor may request or receive additional

information and documentation from the provider, injured employee or payer, who shall cooperate and provide the Commission or its contractor with any necessary medical information, including information pertaining to the payer's decision.

H. Before the Commission or its contractor issues a determination denying the request for treatment or services, a good faith effort shall be made to conduct a peer review with the provider requesting authorization to perform the treatment or services.

K. The Commission or its contractor shall issue a written determination of its administrative review that contains the name and title of the person that performed the administrative review, and includes the following information:

1. Whether the request for treatment or services is authorized or denied, in whole or in part;
2. The information reviewed;
3. The principle reason for the decision; and
4. The clinical basis and rationale for the decision.

a. Reasons for adverse determination. Pursuant to Page 101, A.A.C. § R20-5-1309(H)(5), a payer shall include the following information in its written decision to approve or deny, in whole or in part, the request for preauthorization to provide treatment or services: A statement of explanation if the request for preauthorization is denied, in whole or in part, which should include the medical reason supporting the payer's decision.

b. Notice of Rights to Reconsideration. Pursuant to Page 101, A.A.C. § R20-5-1309(H)(6), a statement of the process under which a provider or injured employee may request reconsideration or review of the payer's denial, in whole or in part, of a request for preauthorization, which shall include the following information;

a. For a decision that is issued without obtaining an IME that is not subject to Page 100, R20-5-1304(B): "If you wish to request reconsideration of the decision regarding your request for preauthorization to provide treatment or services, you must send a written request for reconsideration to:
Name of Payer or Review Organization Identified by Payer
Commission Address, Phone, Fax, E-mail.
You must include the specific reason and justification to support your request. Please include additional supporting medical documentation if not previously provided."

For a decision that is supported by an IME:
"If you wish review of the decision regarding your request for preauthorization to provide treatment or services, then the injured employee is required to file a request for investigation under A.R.S. § 23-1061(J)."

c. For a decision that is issued without obtaining an IME that is subject to Page 100, R20-5-1304(B):
"If you disagree with this decision and wish to request review by the Industrial Commission of Arizona, then you may submit a request for administrative review under R20-5-1311, Page 102 to:
Industrial Commission of Arizona
Attn: Medical Resource Office
Commission Address
Commission Telephone Number
The provider shall file this request promptly and include the following information: patient information, including name, address, payer claim number, Commission claim number, and date of injury; diagnosis or ICD code; employer, insurance carrier or TPA information; provider information; information pertaining to request for treatment, including the justification for treatment; applicable treatment guideline or guidelines; denial of treatment by payer; copies of relevant medical information or records; and whether the request for medical treatment or services involves a request for urgent care or a life-threatening condition."

B. Reconsideration requirements. Pursuant to Page 101, A.A.C. § R20-5-1309(E), Unless the payer decision was supported by an IME or otherwise falls on Page 100, subsection R20-5-1304(B), an injured employee or provider may seek reconsideration of a payer decision by

submitting a written request to the payer (or review organization identified by the payer) that states the specific reasons and justifications to support the request. If not previously provided, the injured employee or provider shall include supporting medical documentation with their written request.

Pursuant to Page 102, A.A.C. § R20-5-1310(E), A payer shall include the following information in its written decision to approve or deny, in whole or in part, a request for reconsideration of a denial of preauthorization:

1. The date on which the request for reconsideration was received;
2. Patient information, including date of injury, date of birth, payer claim number and Commission claim number;
3. The date on which an IME was completed, if applicable;
4. A statement of what has been authorized including, if applicable, a partial authorization;
5. A statement of explanation if the request for treatment is denied, in whole or in part; and
6. A statement of the process under which a provider or injured employee may request Commission review of the payer's denial, in whole or in part, of a request for preauthorization, which shall include the following information:

a. For a reconsideration decision that is issued without obtaining an IME: "If you disagree with this reconsideration decision and wish to request review by the Commission, then you may submit a request for administrative review under R20-5-1311, Page 102 to: Industrial Commission of Arizona Attn: Medical Resource Office Commission Address Commission Telephone Number

The provider shall file this request promptly and include the following information: patient information, including name, address, payer claim number, Commission claim number, and date of injury; diagnosis or ICD code; employer, insurance carrier or TPA information; provider information; information pertaining to request for treatment, including the justification for treatment; applicable treatment guideline and denial of treatment by payer; copies of relevant medical information or records; copies of relevant documentation related to the payer reconsideration decision; and whether the request for medical treatment or services involves a request for urgent care or a life-threatening condition."

b. For reconsideration of a decision that is supported by an IME: "If you disagree with this reconsideration decision and wish review by the Commission, then the injured employee is required to file a request for investigation under A.R.S. § 23-1061(J)."

(F) A payer shall provide a copy of its written reconsideration decision to deny treatment or services to the injured employee.

Administrative Review by Commission Decision Requirements.

Pursuant to Page 102, A.A.C. § R20-5-1311(K), the Commission or its contractor shall issue a written determination of its administrative review that contains the name and title of the person that performed the administrative review, and includes the following information:

1. Whether the request for treatment or services is authorized or denied, in whole or in part;
2. The information reviewed;
3. The principle reason for the decision; and4. The clinical basis and rationale for the decision.

1. Time frame for determination.

Pursuant to Page 102, A.A.C. § R20-5-1310,

(A) Except as provided in subsection (C), a payer shall communicate to the provider its decision on a request for reconsideration no later than 10 business days after the request is received. This decision shall comply with the requirements set forth in subsection (E). For purposes of this subsection, the 10 business days begin to run the day after the payer receives the request for reconsideration.

(B) If a payer fails to respond to a request for reconsideration within 10 business days, the provider or injured employee may submit a request for administrative review directly to the Commission as provided on Page 102, R20-5-1311.

(C) If, no later than 10 business days after a request for reconsideration has been received, a payer provides notice to the provider that an IME has been requested under R20-5-114, Page 12, then the payer's decision on a request for reconsideration shall be issued no later than 10 business days after the final IME report has been received by the payer. The payer shall provide a copy of the final IME report to the provider upon receipt of the report.

2. External appeals.

"If your claim is denied or if you disagree with the amount of compensation awarded,

you have 90 days to file a request for a hearing. To do so, you must complete and submit a hearing request form to the ICA. You can also simply write a letter to the ICA requesting a hearing and stating the reason for your request.
After you file a request for a hearing, you will receive a letter from the ICA with the date and time of your hearing. You will normally wait about three months to have a hearing before a workers' comp judge. This is so you and your employer can gather evidence and prepare your case. In some cases, there may be more than one hearing held before a decision is issued."
http://www.disabilitysecrets.com/resources/arizona-workers%E2%80%99-compensation-filing-benefits-appeals.htm
Hearing Request Form:
https://www.azica.gov/claims-request-hearing
Pursuant to Page 101, A.A.C. § R20-5-1309(F), an injured employee may seek review of a payer decision that is supported by an IME by requesting an investigation under A.R.S. § 23-1061(J).
G. Unless the decision was supported by an IME, an injured employee or provider may seek review of a payer decision issued under R20-5-1304(B), Page 100, by requesting administrative review by the Commission as provided in R20-5-1311, Page 102.
Commission Review of Payer Reconsideration Decision.
Pursuant to Page 102, A.A.C. § R20-5-1310(D),
1. An injured employee or provider may seek review of a payer reconsideration decision by requesting an administrative review by the Commission as provided in R20-5-1311, Page 102 unless the payer decision was supported by an IME.
2. An injured employee may seek review of a payer reconsideration decision that is supported by an IME by requesting an investigation under A.R.S. § 23-1061(J).
L. An interested party dissatisfied with the administrative review determination may request that the dispute be referred to the Commission's Administrative Law Judge Division for hearing. This request for hearing shall:
1. Be in writing;
2. Filed no later than 10 business days after the administrative review determination is issued; and
3. State whether the party requests to participate in the Fast Track ALJ Dispute Resolution Program by stipulation, or declines to participate in the Fast Track ALJ Dispute Resolution Program.
M. If a timely request for hearing is filed, the administrative review determination is deemed null and void and shall serve no evidentiary purpose.

C. Emergency Services.
No provision.

Regulator review pending.
Updated by RegQuest staff on August 11, 2018.