

**ALABAMA DEPARTMENT OF INDUSTRIAL RELATIONS  
ADMINISTRATIVE CODE**

**RULE**

Division: Workers' Compensation  
Chapter: Utilization Management and Bill Screening  
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480-5-5-.07 **UTILIZATION REVIEW PROCESS.**

(1) It is the express intent of these Rules that utilization review may be performed by the insurance carrier, employer/agent, self-insured employer, or group self-insurance fund. There is no requirement that outside utilization review entity vendors be hired to perform utilization review activated in accordance with these Rules. Entities qualified by the Department may perform certain functions as herein described and permitted by these Rules.

(2) **Technical Reviewer** - It is the express intent of these Rules that approval of medical services may be performed by the employer/agent, or its designated employee which may include, but is not limited to, the Technical Reviewer. The employer/agent or designated employee shall not deny a medical service but shall refer any medical services which may not be approved to the first level of clinical review.

(3) **First Level Clinical Review** - Medical services that do not meet the criteria for first level clinical review shall be referred to the second level of review prior to a non-certification or denial determination.

(4) **Second Level Clinical Review:**

(a) If the physician performing the second level clinical review is not a peer to the ordering physician and a decision to approve the request cannot be rendered, the second level clinical reviewer shall:

1. Notify the requesting provider that up to 48 hours will be allowed for the purpose of a review by the requesting provider's peer, and

2. Refer the request for a review by the requesting provider's peer.

(b) The physician or medical director performing second level clinical review shall be reasonably available (within one business day) by telephone or in person to discuss the determination with the attending physician and/or other ordering providers.

(c) Upon request by the attending physician or other ordering provider, a

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non-certification or denial of payment for medical services pursuant to the Second Level Clinical Review process shall be reviewed pursuant to the Peer Clinical Review (Third Level Clinical Review) process. The Third Level Clinical Reviewer shall not be the same peer that rendered a denial or adverse determination at the Second Level Clinical Review.

**(5) Peer Clinical Review (Third Level Clinical Review):**

(a) Expedited Appeal - When a determination not to certify a medical service is made prior to or during an ongoing service requiring review, and the provider believes that the determination warrants immediate appeal, the provider shall have an opportunity to appeal that determination over the telephone on an expedited basis. Each qualified utilization review entity shall provide for reasonable access to its consulting Peer Clinical Review providers for such appeals. Both the provider and qualified utilization review entity shall share the maximum information by phone, facsimile or otherwise to resolve the expedited appeal (sometimes called a reconsideration request) satisfactorily. Expedited appeals that do not resolve a difference of opinion between the provider and the URE may be resubmitted through the standard appeal process. The expedited appeal process applies only when the provider and the URE mutually agree that an expedited appeal is necessary to resolve a dispute involving a denial of proposed treatment.

(b) Standard Appeal - The qualified utilization review entity shall establish procedures for appeals to be made in writing and/or by telephone.

1. Each qualified utilization review entity shall notify in writing the attending physician and claims administrator of its determination on the appeal as soon as practical, but in no case later than 30 days after receiving the required documentation on the appeal.

2. The documentation required by the qualified utilization review entity may include copies of part or all of the medical records and/or a written statement from the provider.

3. Prior to upholding the original decision not to certify for clinical reasons, the qualified utilization review entity shall obtain a review of such documentation by a Peer Clinical Review (Third Level Clinical Review) provider who was not involved in the original determination.

4. The process established by a qualified utilization review entity may include a time period within which an appeal shall be filed to be considered.

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5. An attending physician or other ordering provider who has been unsuccessful in an attempt to reverse the appealed determination shall be provided the clinical basis for the upheld determination upon request.

6. The claimant may request through the ordering provider that a Third Level Clinical Review be conducted, if a denial or adverse determination is received at the Second Level Clinical Review.

(6) Notification of Adverse Determination Due to the Utilization Review Process - Notwithstanding any other provision of Rules 480-5-5-.01 through .35, a response shall be generated in writing (letter or facsimile) if the treatment or admission is denied. Copies of the written response, if required, shall be sent to the provider and shall notify the party of the right to appeal and the appeal process. The denial letter shall contain the following elements: claimant's name, the claimant's identifying number and address; date of accident; treatment or service denied; effective date of the denial; name of provider or facility; reason for denial; and the appeals process. The claimant shall be copied on all denial letters.

Author: Workers' Compensation Medical Service Board

Statutory Authority: Code of Alabama, 1975, '25-5-293

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