

**ALABAMA DEPARTMENT OF INDUSTRIAL RELATIONS
ADMINISTRATIVE CODE**

RULE

Division: Workers' Compensation
Chapter: Utilization Management and Bill Screening
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480-5-5-.11 TECHNICAL CONSIDERATIONS FOR REVIEW (BILL SCREENING) OF CLAIMS.

(1) Prior to a detailed medical review, a review of the claim shall be accomplished as a part of the initial bill screening process and shall include at least the following:

- (a) Identifying the job related illness/injury;
- (b) Identifying each service/item billed;
- (c) Identifying the billing period;
- (d) Determining that appropriate forms were used and filled out completely.

(2) If the review indicates that sufficient information is present, review of the claim shall proceed. If the review indicates information is lacking, the employer/agent shall take immediate and appropriate action, as outlined in Rule 480-5-5-.03(1), to obtain the information required.

(3) The determination of Medical Necessity/Cost Effective Setting shall:

- (a) Be consistent with the diagnosis and treatment of a condition or complaint;
- (b) Be consistent with the standard of care for good medical practice;
- (c) Not be solely for the convenience of the patient, family, hospital, physician or other provider;
- (d) Be in the most appropriate and cost effective medical care setting as determined by the patient's condition; and
- (e) Be the responsibility of the physician or other provider for the final decision regarding the setting in which the procedure is to be performed.
- (f) Reimbursement shall be made according to the place of service in which the treatment or service was pre-certified.

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(4) Confidentiality - When it is necessary to request additional information to clarify the need for services or to substantiate coverage for a claim being reviewed, the employer/agent shall take particular care to ensure that all of its employees adhere to strict policy guidelines regarding the claimant's privacy. If written material is required, the request shall be made in accordance with Rule 480-5-5-.03. The employer/agent shall require only sufficient information to allow a reviewer to make an independent judgment regarding diagnosis and treatment.

(5) In addition to the claim form, the following shall be the minimum documentation requirements of any documentation requested by the payor prior to payment in accordance with Rule 480-5-5-.03:

(a) Documentation for all services shall be legible and signed by the health care provider; and

(b) Submitted documentation shall contain sufficient data to substantiate the diagnosis and need for treatment on each date of service.

(c) To substantiate medical necessity:

1. The most complete and precise diagnosis shall be reported on the claim;
2. Service(s) billed shall be appropriate for the diagnosis;
3. Documentation in the clinical record (i.e., physical findings and historical data) shall confirm the diagnosis(es) and support the medical necessity and appropriateness of the medical service billed; and
4. Documentation shall be available for each service billed.

(6) Detection - The employer/agent shall conduct an ongoing program to detect the misuse of benefits through routine claims review, claims audit and the investigation of complaints. Referrals of misuse shall be made to the applicable agency.

(7) Complaints - Complaints from claimants, carriers, employers, physicians, other practitioners, health care facilities, referrals from internal areas of the Workers' Compensation Division, and other information concerning utilization review or bill screening may be referred to an Ombudsman for medical dispute resolution whose decision is reviewable by the Medical Services Board.

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(8) On-site Audit of Charges - The employer/agent shall be authorized to conduct an on-site audit, as stated in Rule 480-5-5-.25, of any provider of services related to a compensable injury or illness.

Author: Workers' Compensation Medical Services Board

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

History: Effective September 12, 1996