

**RULES  
OF  
TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT  
DIVISION OF WORKERS' COMPENSATION**

**CHAPTER 0800-02-06  
GENERAL RULES OF THE WORKERS' COMPENSATION PROGRAM  
UTILIZATION REVIEW**

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**0800-02-06-.01 DEFINITIONS.**

The following definitions are for the purpose of these Utilization Review Rules, Chapter 0800-02-06:

- (1) "Act" means the Tennessee Workers' Compensation Act, T.C.A. §§ 50-6-101, et seq., as amended.
- (2) "Administrator" means the chief administrative officer of the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development, or the Administrator's designee.
- (3) "Advisory Medical Practitioner" means an actively Tennessee-licensed practitioner, who is board certified, who is in good standing, who is in the same or similar general specialty as the recommending authorized treating physician, and who makes utilization review determinations for the utilization review agent or the Department.
- (4) "Authorized Treating Physician" means the practitioner chosen from the panel required by T.C.A. § 50-6-204 or a practitioner referred to by the practitioner chosen from the panel required by T.C.A. § 50-6-204, as appropriate. Authorized Treating Physician shall also include any other medical professional recognized and authorized by the employer or designated by the Division to treat any injured employee for a work-related injury or condition.
- (5) "Business day" means any day upon which the Workers' Compensation Division is open for business.
- (6) "Commissioner" means the Commissioner of the Tennessee Department of Labor and Workforce Development, the Commissioner's Designee, or an agency member appointed by the Commissioner.
- (7) "Consultation fee" means a fee for a practitioner who provides consultation services to the Division for the purpose of determining an appeal pursuant to this Chapter. Such fee shall be prescribed by the Commissioner and posted on the division's website. Such fee shall not increase or decrease except after thirty (30) calendar days from the date a notice of increase or decrease is posted on the Division's website.
- (8) "Contractor" means an independent utilization review organization not owned by or affiliated with any carrier authorized to write workers' compensation insurance in the state of

(Rule 0800-02-06-.01, continued)

Tennessee with which the Commissioner has contracted to provide utilization review, including peer review, for the Division, as referred to in T.C.A. § 50-6-124.

- (9) "Department" means the Tennessee Department of Labor and Workforce Development.
- (10) "Division" means the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development.
- (11) "Employee" means an employee as defined in T.C.A. § 50-6-102, but also includes the employee's representative or legal counsel.
- (12) "Employer" means an employer as defined in T.C.A. § 50-6-102, but also includes an employer's insurer, third party administrator, self-insured employers, self-insured pools and trusts, as well as the employer's representative or legal counsel, as applicable.
- (13) "Health care provider" includes, but is not limited to, the following: licensed individual, chiropractor, dentist, physical therapist, physician, surgeon, group of practitioners, hospital, free standing surgical outpatient facility, health maintenance organization, industrial or other clinic, occupational healthcare center, home health agency, visiting nursing association, laboratory, medical supply company, community mental health center, and any other facility or entity providing treatment or health care services for a work-related injury
- (14) "Inpatient services" means services rendered to a person who is formally admitted to a hospital and whose length of stay exceeds twenty-three (23) hours.
- (15) "Medical Director" means the Medical Director of the Division appointed by the Commissioner pursuant to T.C.A. § 50-6-126, or the Medical Director's designee chosen to act on behalf of the Medical Director.
- (16) "Medical necessity" means health care services that a practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are in accordance with generally accepted standards of medical practice.
- (17) "Outpatient services" means a service provided by the following, but not limited to, types of facilities: physicians' offices and clinics, hospital emergency rooms, hospital outpatient facilities, community mental health centers, outpatient psychiatric hospitals, outpatient psychiatric units, and freestanding surgical outpatient facilities also known as ambulatory surgical centers. Outpatient services also include hospital admissions for a patient whose length of stay does not exceed twenty-three (23) hours.
- (18) "Parties" means the employee, authorized treating physician and employer as those terms are defined herein.
- (19) "Practitioner" means a person currently licensed in good standing to practice as a doctor of medicine, doctor of osteopathy, doctor of chiropractic, or doctor of dental medicine or dental surgery.
- (20) "Recommended treatment" means the recommendation of the authorized treating physician to perform or refer treatments, procedures, surgeries, and/or admissions in either an inpatient or outpatient setting. Recommended treatment shall also mean emergency treatments, procedures, surgeries, and/or admissions when retrospective review is performed.
- (21) "Records" means medical records and reports regarding an employee's claim for workers' compensation benefits. Records include electronic imaging of such documents.

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- (22) "Standard appeal fee" means a fee charged by the Division for the purpose of determining an appeal pursuant to this Chapter. Such fee shall be prescribed by the Commissioner and posted on the Division's website. Such fee shall not increase or decrease except after thirty (30) calendar days from the date a notice of increase or decrease is posted on the Division's website.
- (23) "Utilization review" means evaluating the quality and appropriateness of health care or health care services in workers' compensation cases pursuant to the timeframes, procedures, and requirements of this Chapter, 0800-02-06, and as defined in T.C.A. § 50-6-102. The employer shall be responsible for all costs associated with utilization review and shall in no event obligate the employee, health care provider or Department to pay for such services.
- (24) "Utilization review agent" means an individual or entity authorized to do business in Tennessee, having certified to the Commissioner of Commerce and Insurance pursuant to T.C.A. §§ 56-6-701, et seq., and registered with the Division.

**Authority:** T.C.A. §§ 50-6-102, 50-6-124, 50-6-126, and 50-6-233. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed May 13, 1997; effective July 27, 1997. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009.

#### **0800-02-06-.02 UTILIZATION REVIEW SYSTEM.**

- (1) This Chapter shall apply to all recommended treatments for work-related injuries or conditions whenever the recommendation is made after this Chapter, as amended, becomes effective.
- (2) Employers shall establish and maintain a system of utilization review. An employer may choose to provide utilization review services itself, through its insurer or through a third party administrator. Whenever utilization review is conducted, whether mandatory under this Chapter, 0800-02-06, or not, such utilization review shall be conducted in complete conformity with this Chapter. Failure to comply with this Chapter in any way may subject the employer and utilization review agent to sanctions and/or civil penalties as set forth in Rule 0800-02-06-.10. The Medical Director or a workers' compensation specialist may determine whether a utilization review was conducted in conformity with this Chapter and may determine that a utilization review is void.
- (3) The Commissioner may provide or contract for certain utilization review services with a Contractor. The Contractor may provide any service allowed by T.C.A. § 50-6-124, including, but not limited to, reviewing utilization review services and providing peer review. The parties shall cooperate and provide any necessary medical information to the Contractor when requested, which shall not constitute a waiver of any applicable privilege or confidentiality.
- (4) Any organization conducting utilization review for workers' compensation cases pursuant to this Chapter shall provide to the Administrator copies of any information provided to the Commissioner of Commerce and Insurance pursuant to T.C.A. § 56-6-704. Any organization conducting utilization review for workers' compensation cases must also register with the Division on a form prescribed by the Administrator. Failure to certify to the Commissioner of Commerce and Insurance and be registered with the Division prior to performing utilization review services may result in sanctions and/or civil penalties pursuant to Rule 0800-02-06-.10 of this Chapter.
- (5) Subject to any applicable requirements of law concerning confidentiality of records, a utilization review agent shall provide the Division, including the Medical Director, with any

(Rule 0800-02-06-.02, continued)

appropriate utilization review records or permit the Division to inspect, review, or copy such records in a reasonable manner. The Division will maintain any required confidentiality of any personally identifying information concerning employees claiming workers' compensation benefits. Provision of these records pursuant to this rule shall not constitute a waiver of any applicable privilege or confidentiality.

- (6) In no event shall an individual concurrently perform case management services, as set forth in Chapter 0800-02-07, and utilization review with regard to a single claim of work-related injury.
- (7) Billing and payment for any medical services provided in conjunction with this Chapter shall be subject, as applicable, to the Division's Medical Cost Containment Program, Medical Fee Schedule, or In-Patient Hospital Fee Schedule rules contained in Chapters 0800-02-17, 0800-02-18, and 0800-02-19, respectively.

**Authority:** T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126, and 50-6-233. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed May 13, 1997; effective July 27, 1997. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009.

#### **0800-02-06-.03 UTILIZATION REVIEW REQUIREMENTS.**

- (1) In any case in which utilization review is undertaken, the utilization review agent shall make an objective evaluation of the recommended treatment as it relates to the employee's condition and render a determination concerning the medical necessity of the recommended treatment. A utilization review agent may contact the authorized treating physician regarding the recommended treatment pursuant to applicable law; provided that such contact shall not constitute a waiver of any other applicable privilege or confidentiality.
- (2) Upon initiation of utilization review, the authorized treating physician shall submit all necessary information to the utilization review agent and shall certify that the information is a complete copy of the health care provider's records and reports that are necessary for utilization review. The authorized treating physician shall also include the reason(s) for the necessity of the recommended treatment in such records and reports. The employer, or other payer, shall reimburse the authorized treating physician for the costs of copying and transmitting such records; provided that the costs do not exceed the amounts prescribed by T.C.A. § 50-6-204. If a dispute arises as to the necessity of information, then the parties shall proceed as set forth in Rule 0800-02-06-.06(5).
- (3) Upon receipt of all necessary information, the initial utilization review decision may be determined by a licensed registered nurse whenever the recommended treatment is being approved. For all denials, the utilization review decision shall be determined by an advisory medical practitioner and communicated to the parties in a written utilization review report.

**Authority:** T.C.A. §§ 50-6-102, 50-6-124, 50-6-126, and 50-6-233. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009.

#### **0800-02-06-.04 CONTENTS OF UTILIZATION REVIEW REPORT.**

- (1) The utilization review agent shall communicate its determination to the parties within the timeframe established in Rule 0800-02-06-.06. If the utilization review determination is a denial of a recommended treatment, then the utilization review agent shall submit a written utilization review report in conformity with the requirements of subsection (2) of this Rule. If the utilization review determination is an approval of a recommended treatment, then the

(Rule 0800-02-06-.04, continued)

utilization review agent shall submit written documentation of the determination; provided that the written documentation is not required to be a utilization review report in conformity with the requirements of subsection (2) of this Rule. A utilization review report and other written documentation may be communicated through electronic means when available.

- (2) The utilization review report shall adhere to the following requirements:
  - (a) The utilization review agent shall only consider the medical necessity, appropriateness, efficiency, and quality of the recommended treatment for the employee's condition.
  - (b) Whenever a utilization review agent determines that the recommended treatment will be denied, the utilization review report must contain specific and detailed reasons for the denial.
  - (c) The utilization review agent shall also include the name, address, phone number and qualifications of the advisory medical practitioner making a denial determination.
  - (d) All utilization review reports that deny a recommended treatment shall include an appeal form prescribed by the Division. The utilization review agent shall transmit a copy of the utilization review report and appeal form to the authorized treating physician, employee, and employer. Upon request, the utilization review agent shall transmit any utilization review report to the Division. Failure to include the appeal form in the utilization review report and transmit such to all parties may result in sanctions and/or civil penalties pursuant to Rule 0800-02-06-.10 of this Chapter.

**Authority:** T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126, and 50-6-233. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed May 13, 1997; effective July 27, 1997. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009.

#### **0800-02-06-.05 MANDATORY UTILIZATION REVIEW.**

- (1) The parties are required to participate in utilization review under this Chapter whenever a dispute arises as to the medical necessity of a recommended treatment.
- (2) Utilization review is required to be performed pursuant to the requirements of this Chapter whenever it is mandated by T.C.A. § 50-6-124 or the Division's Medical Cost Containment Program, Medical Fee Schedule, or In-Patient Hospital Fee Schedule rules contained in Chapters 0800-02-17, 0800-02-18, and 0800-02-19, respectively.

**Authority:** T.C.A. §§ 50-6-102, 50-6-124, 50-6-126, and 50-6-233. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009.

#### **0800-02-06-.06 TIME REQUIREMENTS.**

- (1) If a recommended treatment requires utilization review, then an employer shall submit the case to its utilization review agent within three (3) business days of the authorized treating physician's notification of the recommended treatment, subject to subsection (5) of this Rule. The authorized treating physician's notification of the recommended treatment to the employer shall, at a minimum, be in a form that confirms transmission by showing the time and date of receipt (e.g., facsimile). The employer shall notify all parties upon submitting the case to its utilization review agent, and shall also notify any workers' compensation specialist assigned to the claim. If the employer fails to comply with this subsection, then the employer

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may be subject to sanctions and/or civil penalties pursuant to Rule 0800-02-06-.10 of this Chapter.

- (2) The utilization review agent shall render the determination and communicate the determination in writing to the authorized treating physician, employee and employer within seven (7) business days of receipt of the case from the employer, subject to subsection (5) of this Rule. If a denial, the utilization review report shall list all records and supplemental material reviewed by the utilization review agent. Upon request, the authorized treating physician or employee may obtain copies of any such records and supplemental material reviewed by the utilization review agent. The utilization review report shall also include an appeal form prescribed by the Division on which the utilization review agent shall identify the state file number associated with the claim for which treatment is being recommended, if any, and shall identify the utilization review agent's certification number issued by the Division. If the utilization review agent fails to comply with this subsection, then the utilization review agent may be subject to sanctions and/or civil penalties pursuant to Rule 0800-02-06-.10 of this Chapter.
- (3) If a denial of the recommended treatment is appealed, then the utilization review agent shall send a copy of the utilization review report and all records reviewed by the utilization review agent to the Division upon request.
- (4) An approval of a recommended treatment by the employer's utilization review agent shall be final and binding on the parties for administrative purposes.
- (5) When there is a dispute over a request for information, the following timeframes shall apply:
  - (a) If the employer or utilization review agent does not possess all necessary information in order to dispute the recommended treatment or render the utilization review determination, then it shall immediately make a written request for such information to the authorized treating physician, who shall comply with the written request within five (5) business days of receipt of the written request. The time requirements in subsections (1)-(2) of this Rule shall be tolled until the employer or utilization review agent receives the necessary information or until the timeframe set forth in the preceding sentence expires, whichever occurs first.
  - (b) Denials for inadequate information may be appealed pursuant to Rule 0800-02-06-.07, at which time the authorized treating physician shall submit all information deemed to be necessary by the Division. If the Division finds that the employer's or utilization review agent's request did not pertain to necessary information, then the employer or utilization review agent may be subject to sanctions and/or civil penalties as set forth in Rule 0800-02-06-.10, at the discretion of the Commissioner. In addition, if an authorized treating physician fails to cooperate and timely furnish all necessary information, records and documentation to an employer or utilization review agent, then the authorized treating physician may be subject to sanctions and/or civil penalties as set forth in Rule 0800-02-06-.10, at the discretion of the Commissioner.
- (6) Employer's obligations upon receipt of utilization review determination:
  - (a) Within three (3) business days of receiving a utilization review determination that denies the recommended treatment, the employer shall give written notification to the employee and authorized treating physician as to whether the employer will authorize any of the recommended treatments that were denied by the utilization review agent and what, if any, conditions shall apply to such authorization.

(Rule 0800-02-06-.06, continued)

- (b) Within three (3) business days of receiving a utilization review determination that is either an approval or denial, the employer shall forward such determination to any workers' compensation specialist assigned to the claim. The employer shall also forward the notification described in subsection (6)(a) above, if applicable.

**Authority:** T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126, and 50-6-233. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed March 15, 1995; effective July 28, 1995. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009.

#### **0800-02-06-.07 APPEALS OF UTILIZATION REVIEW DECISIONS.**

- (1) Every denial of a recommended treatment shall be accompanied by a form prescribed by the Division that informs the employee and authorized treating physician how to request an appeal with the Division. The employee or authorized treating physician shall have thirty (30) calendar days from receipt to request an appeal with the Division.
- (2) Upon receipt of an appeal request by an employee or authorized treating physician:
  - (a) The Division shall conduct the utilization review appeal. The Division may contact the authorized treating physician for peer review purposes. The Division shall determine the medical necessity of the recommended treatment within twenty-five (25) business days after receipt of all necessary information. The Division shall then transmit such determination to the authorized treating physician, employee, and employer. The determination of the Division is final for administrative purposes, subject to the provisions of subsections (3)-(5) of this Rule.
  - (b) If any information necessary for the determination of the appeal is not within the possession of the Division, then the timeframe in subsection (a) shall be tolled until all such information is submitted and may subject any party withholding such information to sanctions and/or civil penalties as set forth in Rule 0800-02-06-.10, at the discretion of the Commissioner.
  - (c) The employer shall remit the standard appeal fee and/or the consultation fee to the Division. If the applicable fee is not received within ten (10) business days of the issuance of the Division's determination, a late fee of 10% of the applicable fee per day shall accrue until payment is received.
- (3) If the determination of the Division is an approval of the recommended treatment, then a workers' compensation specialist shall issue an order for medical benefits. The penalty provisions of T.C.A. § 50-6-238(d) shall apply to orders issued pursuant to this subsection (3).
- (4) If the determination of the Division is a denial of the recommended treatment, then the parties may file a Request for Benefit Review Conference or may request a waiver of the benefit review conference requirement, as applicable.
- (5) Notwithstanding any other provision to the contrary, if the parties agree on a recommended treatment after the employer's utilization review agent has denied such, then the parties may, by joint agreement, override the determination of the employer's utilization review agent and approve the recommended treatment. Such approval by agreement shall terminate any appeal to the Division and no fee shall be required of the employer for any such appeal that has yet to be determined by the Division.

(Rule 0800-02-06-.07, continued)

**Authority:** T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126, 50-6-233, and 50-6-238. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed March 15, 1995; effective July 28, 1995. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009.

#### **0800-02-06-.08 UTILIZATION REVIEW FORMS.**

- (1) All utilization review agents must file the Utilization Review Notification form (Form C-35) immediately upon initiation of utilization review services on an employee's workers' compensation claim. Only one form is necessary for each claim.
- (2) All utilization review agents must file the Utilization Review Closure form (Form C-36/C-37) immediately following the conclusion of utilization review services on an employee's workers' compensation claim. Only one form is necessary for each claim.
- (3) All utilization review agents must file an annual report on a form prescribed by the Division and accessible through the Division's website.

**Authority:** T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126, and 50-6-233. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009.

#### **0800-02-06-.09 SUBCONTRACTORS.**

- (1) A utilization review agent shall be responsible for any advisory medical practitioner(s) and registered nurse(s) with whom the utilization review agent subcontracts to perform utilization reviews. If a subcontractor performs a utilization review in accordance with the requirements of this Chapter, then the utilization review shall be treated as if performed by the contracting utilization review agent. A utilization review agent shall be liable for all sanctions and/or civil penalties contained in this Chapter whenever its subcontractor violates any provision contained herein.
- (2) A utilization review agent may only subcontract with an advisory medical practitioner as defined in Rule 0800-02-06-.01(3) or registered nurse. All other subcontracting for utilization review services is prohibited and will result in the invalidity of such utilization review determination.

**Authority:** T.C.A. §§ 50-6-102, 50-6-118, 50-6-124, 50-6-126, and 50-6-233. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009.

#### **0800-02-06-.10 SANCTIONS AND CIVIL PENALTIES.**

- (1) Failure by an employer, insurer, third party administrator, or utilization review agent to comply with any requirement in this Chapter, 0800-02-06, including but not limited to applying utilization review when required and complying with the timeframes for utilization review, shall subject such party to a penalty of not less than one hundred dollars (\$100.00) nor more than one thousand dollars (\$1,000.00) per violation at the discretion of the Commissioner. The Division may also institute a temporary or permanent suspension of the right to perform utilization review services for workers' compensation claims, if the utilization review agent has established a pattern of violations.
- (2) A health care provider is subject to the penalties enumerated in T.C.A. § 50-6-124(e) as if set forth fully herein.

(Rule 0800-02-06-.10, continued)

- (3) The penalty for failure to timely file the Form C-35 or Form C-36/C-37 in accordance with Rule 0800-02-06-.08 is twenty-five dollars (\$25) for each fifteen (15) calendar days past the initiation or conclusion of utilization review services, as applicable, per violation. The penalty for failure to file the annual report in accordance with Rule 0800-02-06-.08 is twenty-five dollars (\$25) for each fifteen (15) calendar days past the final date for filing the annual report.

**Authority:** T.C.A. §§ 4-5-314, 50-6-102, 50-6-118, 50-6-124, 50-6-126, and 50-6-233. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009.

#### **0800-02-06-.11 ISSUANCE AND APPEAL OF SANCTIONS AND CIVIL PENALTY ASSESSMENTS.**

- (1) An agency decision assessing sanctions and/or civil penalties shall be communicated to the party to whom the decision is issued, and the party to whom it is issued shall have fifteen (15) calendar days from the date of issuance to either appeal the decision pursuant to the procedures provided for under the Uniform Administrative Procedures Act, T.C.A. §§ 4-5-101, et seq., or to pay the assessed penalties to the Department or otherwise comply with the decision.
- (2) In order for a party to appeal an agency decision assessing sanctions and/or civil penalties, the party must file a petition with the Commissioner within fifteen (15) calendar days of the issuance of the decision. This petition shall be considered a request for a contested case hearing within the Department pursuant to the Uniform Administrative Procedures Act, T.C.A. §§ 4-5-101, et seq., and the procedural rules of Chapter 0800-02-13 are incorporated as if set forth fully herein. The Department is authorized to conduct the hearing pursuant to T.C.A. § 50-6-118.
- (3) If the agency decision assessing sanctions and/or civil penalties is not appealed within fifteen (15) calendar days of its issuance, the decision shall become a final order of the Department not subject to further review.

**Authority:** T.C.A. §§ 4-5-314, 50-6-102, 50-6-118, 50-6-124, 50-6-126, and 50-6-233. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal and new rule filed August 14, 2009; effective November 12, 2009.

#### **0800-02-06-.12 REPEALED.**

**Authority:** T.C.A. §§ 4-5-202, 4-5-203, 50-6-124, 50-6-126, and 50-6-233. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal filed August 14, 2009; effective November 12, 2009.

#### **0800-02-06-.13 REPEALED.**

**Authority:** T.C.A. §§§§ 4-5-202, 4-5-203, 50-6-124, 50-6-126, and 50-6-233. **Administrative History:** Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007. Repeal filed August 14, 2009; effective November 12, 2009.