LEGAL / ADMINISTRATIVE CURRICULUM

OBJECTIVES – ADMINISTRATIVE CURRICULUM

1. Identify the duties and limitations associated with Level I and Level II accreditation.

2. Define “authorized treating physician.”

3. Define “maximum medical improvement” (MMI) and identify the party responsible for determining MMI.

4. Identify the possible payment and benefit consequences of not complying with a request for work status.

5. Explain the procedure used to handle an employee’s failure to attend physician appointment.

6. Explain the manner in which the temporary disability and permanent medical impairment benefits are determined under the workers’ compensation act.

7. Explain the utilization review process and method for revocation of fees under utilization review.

8. Describe the mechanism for revocation of Level II accreditation.

9. Know the required time limits for the WC-164 reports and describe the reimbursement method.

10. Demonstrate the ability to appropriately complete the Colorado Division of Workers’ Compensation *Physician’s Report of Workers’ Compensation Injury* (WC-164) and explain what information belongs in each of the appropriate sections.

11. List recognized physician and nonphysician providers under Rule 16 of the Workers’ Compensation Rules of Procedure.

12. Explain billing for cancellation fees.

13. Define the automatic waiver of patient/doctor privileges in a workers’ compensation case.

Chronology of a Workers' Compensation Case
Administrative Issues in WC

HISTORY OF WORKERS' COMPENSATION

For half a century, some workers unable to continue in their profession have been compensated for their disability. Pirates compensated those who lost extremities, and the Guilds of the 1600's aided families when workers were disabled, usually due to work-related injuries or diseases. In the 1860's, Sir John Simon of England presented a report to the Privy Council in which he established the need for a workers' compensation system by describing the many families left destitute due to industrial injuries. In the United States, two studies from the 1900's, one by the Illinois State Commission and the other by Crystal Eastwood in Pittsburgh demonstrated significant work-related disability compensated inadequately through private charities or the government. Both of these studies found that employers were paying high rates for liability insurance to defend themselves against claims of negligence and very few workers were prevailing in court under the required standard of negligence. Furthermore employers spent at least 53% of their premium dollar on litigation fees and investigation. At the same time, many uncompensated workers became disabled and were dependent on the government social support system, as well as private charities to support their families. This information was instrumental in encouraging employers and labor unions to agree on workers' compensation laws. Under these statutes, injuries, which occurred in relationship to work, would not be litigated by the employer. Further, the employer would not be held to a level of negligence to establish benefits. In exchange the statute would not require payment for pain and suffering but would cover reasonable medical expenses and disability. The employers then had the advantage of limiting the benefits paid, and not having to pay benefits for pain and suffering. All except six states had workers' compensation laws by 1920. These laws generally paid for 1) reasonable medical care, 2) temporary wage loss and 3) permanent wage loss and/or impairment due to loss of extremities or other significant long-term disabilities.

CHRONOLOGY OF A TYPICAL WORKER'S COMPENSATION CASE	Reference to Rule, Statute, Etc.
Injury occurs at work or worker recognizes symptom of illness which may be work-related	§ 8-41-301, C.R.S.
Worker reports incident and symptoms to employer	§ 8-43-102(1)(a) and (2), C.R.S.
Employer files a First Report of Injury form with insurance carrier	
If employer does not concur that a work-related injury or disease exists and refuses to file a First Report form, the worker can file a Worker's Claim for Compensation directly with the Division of Workers' Compensation.	§8-43-103(1), C.R.S.
Worker must seek care with the provider designated by the employer.	
The employer has the right in the first instance to select the authorized treating physician (defined under the statute as an M.D., D.O., chiropractor, podiatrist, or dentist). The claimant is presented with a list of at least two physicians, two clinics, or combination thereof, from which the worker must choose a primary treating physician. If the employer does not timely designate a list of at least two providers when the worker reports an injury, then the worker may see the physician of his/her choice. The physician whom the employee sees on the first visit becomes the authorized provider and remains the authorized provider unless the insurer and patient agree to change providers, the worker exercises an option for one unchallenged change of treating physician, or a judge orders a change in provider. Note that the provider is physician-specific. A provider is not a clinic or organization. Chiropractors must be Level I accredited to treat cases with three or more lost work days or to provide more than 12 treatments or to provide treatment exceeding 90 days. The first physician seen by the worker, meeting the above definitions, becomes the "authorized treating physician." Other physicians referred-to by this physician also become authorized treating providers.	§8-43-404(5), C.R.S. and §8-42-101(1)(a); (3)(a) (III); (3.6), C.R.S.

Responsibilities of a physician at the first visit

1. Take a complete history including job duties, details regarding accident or hazardous exposure and related symptoms, additional past medical history, and history of non-occupational activities.
2. Perform a complete physical examination for all relevant body parts based on the history and patient complaints.
3. Render a diagnosis based on the above.
4. Determine the medically probable cause (greater than 50% likelihood) of the patient's condition. (Causation will be explored in detail in the following chapter.)
5. If it is determined that the patient's condition is not work-related, recommend to the patient that they return to their general health care provider for care. If you find the condition to be work-related, continue your treatment plan.
6. Order appropriate diagnostic studies and initial treatment (refer to relevant Colorado Division of Workers' Compensation Medical Treatment Guidelines).
7. Determine work and activity restrictions.

Rules of Procedure, Rule 17

If the patient has any restrictions of normal activities of daily living (ADL's) or restrictions for specific job tasks, these restrictions must be clearly described. Examples would be:

- Occasional lifting up to 20 pounds
- Frequent lifting limited to 5 pounds
- No over-head work
- Sitting limited to 20 minutes followed by the change in position

NEVER order, "Modified duty," "desk duty," "light duty," etc. Supervisors differ greatly in their interpretation of these terms.

- Give a copy of work restrictions to the patient and ensure that the supervisor receives a copy.

§8-42-105; §8-42-106, C.R.S

Once a worker is off work for three days he becomes eligible for compensation. If the worker is totally restricted from duty, or if the employer cannot provide suitable accommodated duty, he is compensated 66.6% of his wages to a maximum of 91% of the state average weekly wage ("TTD" or Temporary Total Disability). If the employer allows the worker to return to part-time duty, he is compensated for the remainder of the time in which he cannot work 66.6% of his wages to a maximum of 91% of the state average weekly wage ("TPD" or Temporary Partial Disability). Note: The worker will not receive disability payment unless there is a physician's prescribed limitation of duty.

§8-42-105(2)(d), C.R.S.

Complete the WC164 form ("Physician's Report of Workers' Compensation Injury"), submit within **14 days**, and supply a copy to the insurer and the patient. If you are requested to provide ability to work information and do not, payment for your medical care can be withheld.

Rules of Procedure, Rule 16-7(E).

Follow-up patient visits

1. Continue diagnostic tests and treatment as necessary.

    - Be sure to follow the Division of Workers' Compensation Medical Treatment Guidelines. If the DOWC Guidelines must be exceeded, or treatment the patient requires is not covered in the Guidelines, pre-authorization must be sought from the insurance carrier. Carriers are only required to pay for care that is reasonable and medically necessary.
    - The insurer will not cover treatment of conditions not associated with the work-related illness or injury. If a new diagnosis results secondary to the treatment or complications of the primary diagnosis, this must be explained in your records for treatment to be covered.

    Rules of Procedure, Rule 16-9(A)
    Also see Rule 17 For Treatment Guidelines

2. Return the patient to full duty or specific activity restrictions as appropriate for current functional status.

    Rules of Procedure, Rule 16-7(E) and 16-8.

3. Supply the WC164 Report or copies of your medical records when submitting bills to the insurer.

Patient No Shows

You can only receive a cancellation fee, the lesser of $150 or one-half of the fee of the expected visit, when the insurer scheduled the appointment. Therefore notify the insurer of any no show. The insurer may also stop temporary disability payments if the patient fails to come to the insurer- scheduled visit.
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Rule 18-6(B)
§8-42-105(2)(c)

Billing for Services

The Division of Workers' Compensation establishes a maximum fee schedule. To calculate the fee you must multiply the unit value in the 2008 Relative Values for Physicians© times the conversion rate set by the Division ($8.81 for E&M codes). Billing must be submitted on a CMS 1500 and accompanied by documentation. If a service (1) falls outside of those listed in the medical treatment guidelines, (2) is performed by a nonphysician provider not authorized under the fee schedule, (Authorized providers – audiologist, acupuncturist, LCSW, LPN, LPC, LMFT, NP, OTR, OP, OTC, psychologist, LPT, PA, RN, RT, speech pathologist, surgical technologist), or (3) is listed in rule as preauthorized, it requires prior authorization.

Rule 18-2, 18-4
Rule 16-7

Rule 16-5

To contest a request for prior authorization the insurer must provide a review by a physician in the same or similar specialty including citation of treatment guidelines, if applicable, within seven days of a completed request. Following this, there is a seven-day response period for physician and re-response for insurer. If a payer does not respond timely to a complete prior authorization request, then treatment is deemed authorized

Rule 16-10

Copying Medical Records

You continue to have an ethical responsibility to the patient. You should use your normal procedures for securing signed releases from the patient to forward copies of records to the payer for billing purposes or to any other parties. The statute only provides a "limited waiver of the doctor-patient privilege to persons who are necessary to resolve the claim." The Division does not consider documentation of work restrictions as protected medical records.

§8-47-203(1), C.R.S.

Determination of Maximum Medical Improvement (MMI)

Maximum medical improvement exists when the underlying condition causing the disability has become stable and no further treatment is reasonably expected to improve the condition. MMI does not preclude medical maintenance or alteration of the medical condition with the passage of time.

§8-40-201 (11.5), C.R.S

Continuing treatment to sustain the patient's current level of functioning can be prescribed but should be documented by the physician in the final report.

("Grover Meds"); Grover v. Industrial Commission, 759 P.2d 705 (Colo. 1988)

Patient at MMI

- ✓ Authorized treating physician completes WC164 form as a closing report.
- ✓ Define permanent work restrictions or release to full duty.
- ✓ Declare date of MMI
- ✓ Describe any continuing treatment needed or anticipated.
- ✓ Report impairment if present.

Rules of Procedure, Rule 16-7(E)(1)

If the worker is unable to return to full duty, clearly state permanent physical restrictions. If the worker is unable to return to full duty and the employer cannot accommodate the worker's permanent restrictions, the worker will not receive any further payment for temporary disability after the date of MMI.

§8-42-105(3)(a), C.R.S.

An impairment rating is used to calculate the final payment of permanent partial disability benefits to the worker. To qualify for impairment, the worker must have a permanent alteration of a body part or system that affects his activities of daily living. The AMA Guides 3rd Revised Edition, Rule 12 and the Level II Curriculum must be used to calculate impairment.

Rules of Procedure, Rule 12-1 and 12-2

An impairment rating from the AMA Guides has no direct relationship to disability. Disability is related to whether or not a person is employable in various job positions.

Pursuant to Colorado statute 8-42-101(3.7), C.R.S. 2008: " . . . for purposes of determining levels of medical impairment, the physician shall not render a medical impairment rating based on chronic pain without anatomic or physiologic correlation. Anatomic correlation must be based on objective findings."

§8-42-101(3.7) and 8-42-107(8)(c), C.R.S.

- ✓ Patient or insurer may challenge the impairment rating submitted by the authorized treating physician or their consultant. The authorized treating physician's impairment rating can be challenged by requesting an Independent Medical Examination (IME) agreed-upon by the insurer and the patient, or from the Division of Workers' Compensation panel of Independent Medical Examiners. The current minimum cost for a Division IME is $675.00.

§8-42-107(8)(b)(II); §8-42-107.2, C.R.S.; Rules of Procedure, Rule 11

Additional Administrative Issues

Medical Care Accreditation Commission/Advisory Panel

In 1991 Senate Bill 218 radically changed the Colorado workers' compensation system. This bill created the Medical Care Accreditation Commission to advise the Director of the Division of Workers' Compensation on the development of medical fee schedules, medical treatment guidelines, utilization standards, and medical impairment rating guidelines. The commission developed Level I and Level II certification courses and implemented task forces to deal with medical treatment guidelines and impairment rating issues. The commission was sunsetted in July 1997, however the Director of the Department of Labor and Employment and the DOWC Director continued the MCAC as an advisory committee for a number of years. Currently a medical advisory panel which is larger and somewhat less formal than the MCAC provides input to the Division on medical issues.

Level I and II Accreditation and Impairment Rating

The Director of the Division of Workers' Compensation has established Level I and Level II Accreditation (C.R.S. § 8-42-101(3.6)). Level I Accreditation is only mandatory for chiropractors who desire to treat workers for lost time injuries or for more than 12 treatments. Lost time injuries are those where an injured worker is unable to return to work for more than three days. The Level I Accreditation program has been revised by the Division as an educational course appropriate for all physicians who treat injured workers but do not wish to provide impairment ratings.

Level II Accreditation is required to evaluate an injured worker who has been determined to have permanent impairment by the authorized treating physician. Chiropractors, dentists, podiatrists, psychologists, and audiologists cannot receive Level II accreditation.
(C.R.S. §8-42-101(3.5))

The authorized treating physician providing primary care need not be Level I or Level II accredited to determine MMI or that no impairment is present. If a non-Level II treating physician determines that MMI has been reached and impairment is present, that physician must refer to a Level II accredited physician within 20 days. If this referral is not made, the insurance company has an additional 20 days to refer to a Level II accredited physician.

Accreditation must be renewed every three years and generally requires attending a seminar or completing an educational process specified by the Division. The director may also revoke a physician's accreditation by recommendation of a utilization review panel, or for any of the following: 1) refusal to comply, 2) substantial failure to comply, or 3) two or more incidents of failure to comply with the provisions of the workers' compensation rules, relevant statutes, the AMA Guides to the Evaluation of Permanent Impairment and applicable additions by the Division, medical treatment guidelines or utilization standards, or 4) a misrepresentation on an application for accreditation. An administrative law judge will make recommendations to the director regarding revocation of a physician at a hearing prior to revocation of accreditation.

Authorized Medical Care and Billing

The medical provider is authorized under the following circumstances (C.R.S. § 8-43-404(5)): 1) when the employer timely provides the injured worker with a list of at least two physicians or two clinics from which to choose a doctor, prior to the first treatment for the injury; 2) if an employer fails to provide such list after notice of the injury and the employee selects his/her own physician; and 3) in emergency circumstances. Emergency care is authorized; however once the emergency has ceased the employee must return to an authorized physician.

There are several ways by which an injured worker may seek a change in physician. (1) He/she may exercise an option for an unchallenged 'one-time' change of primary care physician if that request is made within 90 days after the date of injury and before MMI is reached. The new physician must be on the employer's designated provider list. (2) Alternatively, the injured worker may at any time request a change of physician by writing to the insurance carrier or self-insured employer. If the carrier or self-insured employer fails to object, or they agree on the new provider within 20 days, the change in physician becomes automatic. (3) The employee may also petition the Division of Workers' Compensation for a change of physician. A prehearing conference or a more formal hearing may then be held to determine whether there is a reasonable basis for a change of physician.

It is important to remember that medical providers will only be reimbursed for care that is reasonable and necessary, even if they are authorized providers. Providers are expected to use the guidelines and carriers should generally reimburse care prescribed in the guidelines. Multi-specialty task forces created the Medical Treatment Guidelines in Rule 17: low back; cervical spine; thoracic outlet; carpel tunnel; cumulative trauma;

shoulder; chronic pain; traumatic brain injury, lower extremity and complex regional pain syndrome.

No provider can bill a patient for charges in excess of the fee schedule, or in excess of those they have contracted for with the self-insured employer or insurer. Physician must bill using the 2008 Relative Values for Physicians (RVP)©. Rules 16 and 18 describe the procedures for preauthorization and list procedures requiring preauthorization as well as additional codes and fees.

Completion of an impairment rating by the primary authorized treating physician is billed under the Medical Fee Schedule at a maximum of $343.59 for 1.5 hours (per the 2009 Fee Schedule). The fee includes the office visit, submission of the required impairment worksheets, and completion of the WC164 form "closing" report. Fee for the same service when the patient is seen on a referral basis is billed at a slightly higher rate (see Rule 18).

Completion of the WC164 report may be billed separately at a rate of $42 for the *initial* visit with the patient or if the payer specially requests that the report be submitted at a time when the form is otherwise not required. The closing WC164 report may also be billed separately at $42 if the patient is placed at MMI with an assessment of *no* impairment.

Independent Medical Examination Program (IME)

If there is a dispute concerning MMI or impairment rating and the parties cannot agree upon an independent medical examiner, the Division of Workers' Compensation will select an independent medical examiner based on an application by the party who objects to the rating or statement of MMI from the authorized treating physician. The division independent medical examiner's opinion can only be overcome by clear and convincing evidence before an administrative law judge and the parties may not go to hearing until the IME physician has issued a completed report. The Division of Workers' Compensation reviews IME physicians' reports to assure that they are complete and adhere to the basic principles taught in the Level II accreditation curriculum and the AMA Guides, 3rd Ed. (rev.).

An insurer may request a Division IME for purposes of determining an MMI date when an authorized treating physician has not yet declared MMI if: 1) it has been 18 months since the date of injury; and 2) another physician has examined the worker and declares the worker at MMI.

The Division of Workers' Compensation is soliciting board certified physicians for the independent medical examiner panel. The Division

encourages qualified, board certified or eligible specialty physicians to apply. A prepaid fee of $675 has been established for an IME examination. Please contact the IME unit at the Division of Workers' Compensation for information on applying to become a member of the IME Panel.

Utilization Review Program (UR)

Utilization review was implemented to allow review and remedy for inappropriate or unnecessary health care. A panel of experts is selected by the Division to review care rendered in a case. The UR panel reviews all of the medical records and makes recommendations to the Director concerning the necessity and/or appropriateness of care. The committee may recommend by majority vote to change the medical provider. The committee may recommend by unanimous vote that fees be retroactively denied or repaid, or that the physician's accreditation be revoked. In the event of revocation of accreditation, carriers may deny reimbursement for medical services to that provider for up to three years. (C.R.S. § 8-43-501)

Physician-Patient Relationship

In all cases you retain the same obligations toward your patients with work related injuries as with non work-related injuries. Although the workers' compensation statute allows a "limited waiver" for "persons necessary to resolve the claim" the Division suggests you follow the same procedures you routinely use when releasing medical records that frequently contain medical history not directly related to the person's claim. Work restrictions which do not include information regarding specific medical diagnosis or treatment are not considered medical records by the Division of Workers' Compensation. See the attached statements from professional societies for guidance on medical ethics.