

Workers' Comp Rules & Guidelines

Do I Really Need to Know All of the Division of Workers' Compensation Rules?

Objectives:

- List the general principles of the Colorado Division of Workers' Compensation Medical Treatment Guidelines.
- Apply the cervical treatment guidelines to a case.
- Discuss the evaluation procedures recommended in the Colorado Medical Treatment Guidelines for a patient with chronic pain.
- Discuss the role of case management in workers' compensation.
- Explain Rule 17, medical treatment guideline rule; the system of accreditation; and the purpose of the utilization review panel.

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Accreditation C.R.S. §8-42-101(3.5) and (3.6), and Rule 13

Level I accreditation - mandatory for chiropractors to treat patients with more than 3 days of lost time, or who may require more than 12 treatments or treatments over a period exceeding 90 days (whichever comes first).

Level II accreditation - for MDs and DOs only, required for any physician to provide an impairment rating.

Accreditation is for 3 years

Revocation The Director may revoke accreditation for misrepresentation on application; two or more incidents of failure to comply with rules or relevant statutes; or unanimous recommendation by Utilization Review panel.

Utilization Review Panel, C.R.S. §8-43-501 and Rule 10

Purpose: To assure employers pay only for care “reasonably needed at the time of an injury or occupational disease to cure and relieve an employee from the effects of an on-the-job injury”

Committee of 3 providers review care of the provider to determine:

- If change of provider needed – majority vote
- If retroactive denial of payment appropriate – unanimous vote
- If revocation of accreditation recommended – unanimous vote

Musculoskeletal Committee

2 practitioners in same discipline of care as provider under review

1 occupational medicine practitioner

Purpose of the Medical Treatment Guidelines

- 1) “To foster communication, to resolve disputes between provider, payer, patient” - Rule 17
- 2) “To assure appropriate medical care at a reasonable cost” – C.R.S. §8-40-201(13.5)

Provider's Responsibilities Under the Guidelines - Rule 17

For treatment beyond 6 weeks – prepare a diagnosis-based treatment plan with treatment goals and timeframes for completion. If treatment deviates from the guidelines provide written explanation to payer and patient.

Payment for Care - Rule 17

Prior authorization unnecessary if treatment is within the guidelines and prior authorization is not required by Rule 16.

If payer questions care under the guidelines, they must refer to the specific section of the guidelines.

Creation of the Treatment Guidelines

Combination of evidence and consensus.

Peer Group Based – specialist from all disciplines who would treat the medical problem.

Current Guidelines [1993-2007]

Low Back, Cervical Spine, Carpal Tunnel, Cumulative Trauma, Thoracic Outlet, Shoulder, Lower Extremity, Traumatic Brain Injury, Chronic Pain Disorder, Complex Regional Pain Syndrome-1 (RSD).

General Guideline Principles (Below is a summary. An example of the complete general principles, taken from the Chronic Pain Disorder Guideline, follows at the end of this section.)

1. **Education** – patient education on self-management of symptoms and prevention. Also includes education of employers, insurers, and family.
2. **Treatment Duration**
 - Begins at initiation of treatment
 - Time to effect - if no effect within limits change treatment or reassess diagnosis
 - Optimum duration - best duration for most cases
 - Maximum duration should not exceed this limit.

3. **Active Interventions**
Passive and palliative treatment only to facilitate active rehabilitation, therapeutic exercise and functional treatment.
4. **Active Therapeutic Exercise**
To improve strength, endurance, coordination, vocational duties.
5. **Positive Patient Response**
Defined by functional gains; e.g., positional tolerance, range of motion, and activities of daily living.
6. **Re-evaluate every 3-4 weeks**
If no positive patient response re-evaluate diagnosis or treatment.
7. **Surgery**
 - For functional gains not purely pain relief
 - Positive correlation of clinical findings, clinical course and diagnostic tests
 - Presence of a pathologic condition
8. **Six-month time frame**
As many as 50% are unlikely to return to work if out for 6 months or more.
9. **Return to Work**
 - This is part of therapy
 - Careful detailed restrictions must be written e.g. – lifting, pushing, pulling, kneeling, driving, tool use, cold environments
 - Be sure you understand patient's job before return to full duty. If unsure obtain advice of occupational professional.
10. **Delayed Recovery**
 - If no progress at 6-12 weeks consider psychosocial evaluation and interdisciplinary treatment.
 - 3-10% of patients will fall outside of guidelines for additional treatment. The physician must justify additional treatment showing functional gains.
11. **Guideline Recommendations**
 - All recommendations in the Guidelines represent reasonable care in specific cases – regardless of evidence level.
 - Other procedures are specified as not recommended
12. **Care Beyond MMI**
 - Only chronic pain and CRPS-1 Guidelines contain post MMI care recommendations.
 - Other Guidelines are not intended to address post-MMI care.

Organization of the Guidelines:

Initial Diagnostic Procedures

- Hx and PE
- Initial Tests

Follow Up Diagnostic Imaging and Tests

Non-Operative Therapeutic Measures

- Manipulation
- Medication
- Education
- Exercise
- Physical Therapy
- Psychosocial Intervention
- Interdisciplinary Treatment
- Vocational Assessment and Rehabilitation

Operative Procedures

Special Issues

- Diagnosis-Based Treatment and Procedures are found in the Shoulder and Lower Extremity Guidelines
- Cumulative Trauma Guidelines has a unique staging diagram to guide care based on severity.

GENERAL GUIDELINE PRINCIPLES – Example from Chronic Pain Disorder Guideline

The principles summarized in this section are key to the intended implementation of all Division of Workers' Compensation guidelines and critical to the reader's application of the guidelines in this document.

1. **APPLICATION OF THE GUIDELINES** The Division provides procedures to implement medical treatment guidelines and to foster communication to resolve disputes among the provider, payer and patient through the Worker's Compensation Rules of Procedure. In lieu of more costly litigation, parties may wish to seek administrative dispute resolution services through the Division or the office of administrative courts.
2. **EDUCATION** of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of chronic pain and disability. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.
3. **TREATMENT PARAMETER DURATION** Timeframes for specific interventions commence once treatments have been initiated, not on the date of injury. Obviously, duration will be impacted by patient compliance, as well as availability of services. Clinical judgment may substantiate the need to accelerate or decelerate the timeframes discussed in this document.
4. **ACTIVE INTERVENTIONS** emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.
5. **ACTIVE THERAPEUTIC EXERCISE PROGRAM** Exercise program goals should incorporate patient strength, endurance, flexibility, coordination, and education. This includes functional application in vocational or community settings.
6. **POSITIVE PATIENT RESPONSE** Positive results are defined primarily as functional gains that can be objectively measured. Objective functional gains include, but are not limited to, positional tolerances, range of motion (ROM), strength, endurance activities of daily living cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

7. **RE-EVALUATION OF TREATMENT EVERY 3 TO 4 WEEKS** If a given treatment or modality is not producing positive results within 3 to 4 weeks, the treatment should be either modified or discontinued. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.
8. **SURGICAL INTERVENTIONS** Surgery should be contemplated within the context of expected functional outcome and not purely for the purpose of pain relief. The concept of “cure” with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions.
9. **SIX-MONTH TIME FRAME** The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return to work within a six-month timeframe, whenever possible. It is important to note that timeframes may not be pertinent to injuries that do not involve work-time loss or are not occupationally related.
10. **RETURN-TO-WORK** is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations and the patient should never be released to “sedentary” or “light duty.” The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, overhead work, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated.

The practitioner should understand all of the physical demands of the patient’s job position before returning the patient to full duty and should request clarification of the patient’s job duties. Clarification should be obtained from the employer or, if necessary, including, but not limited to, an occupational health nurse, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

11. **DELAYED RECOVERY** Strongly consider a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The Division recognizes that 3 to 10% of all industrially injured patients will not recover within the timelines outlined in this document despite optimal care. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

12. **GUIDELINE RECOMMENDATIONS AND INCLUSION OF MEDICAL EVIDENCE** Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply:

Consensus means the opinion of experienced professionals based on general medical principles. Consensus recommendations are designated in the guideline as “generally well accepted,” “generally accepted,” “acceptable,” or “well-established.”

“Some” means the recommendation considered at least one adequate scientific study, which reported that a treatment was effective.

“Good” means the recommendation considered the availability of multiple adequate scientific studies or at least one relevant high-quality scientific study, which reported that a treatment was effective.

“Strong” means the recommendation considered the availability of multiple relevant and high quality scientific studies, which arrived at similar conclusions about the effectiveness of a treatment.

All recommendations in the guideline are considered to represent reasonable care in appropriately selected cases, regardless of the level of evidence attached to it. Those procedures considered inappropriate, unreasonable, or unnecessary are designated in the guideline as “not recommended.”

13. **TREATMENT OF PRE-EXISTING CONDITIONS** that preexisted the work injury/disease will need to be managed under two circumstances: (a) A pre-existing condition exacerbated by a work injury/disease should be treated until the patient has returned to their prior level of functioning or MMI; and (b) A pre-existing condition not directly caused by a work injury/disease but which may prevent recovery from that injury should be treated until its negative impact has been controlled. The focus of treatment should remain on the work injury/disease.