Division of Workers' Compensation

Level I Curriculum

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DIVISION OF WORKERS' COMPENSATION
MEDICAL PROGRAMS / CONTACT INFORMATION

Division Website: www.colorado.gov/cdle/dwc

All Division Rules of Procedure, official Division forms, Division Interpretive Bulletins, and the Workers' Compensation Act are available from the website. Some examples:

- Form WC164 – Physician's Report of Workers' Compensation Injury
- Form WC-M3 - Psych Rev. 1/06 – Mental Impairment Rating form
- Form WC181 – Medical Billing Dispute Resolution Intake Form
- Form WC188 – Authorized Treatment Physician Request for Prior Authorization
- Form WC36A & B – Advisement for Claimant re: Audio-Recording of IME (English/Spanish)
- DK10 – Apportionment of Spinal Range of Motion
- DK11 – Impairment Rating Tips
- DK14 – Apportionment Calculation Worksheet
- DK15 – Guidance/form letter/flow chart to be followed when discharging a patient for non-medical reasons.

Available *Interpretive Bulletins* address topics in IME, Medical Utilization Review, medical records release and privacy, and the use of nurse-practitioners and physician assistants.

General Customer Service	(303) 318-8700 (888) 390-7936	workers.comp@*state.co.us*
Provider Education	(303) 318-8754	*cdle_dowc_provider_education@state.co.us*
Impairment Rating Questions	(303) 318-8752 (303) 318-8756	*david.indovina@state.co.us* *courtney.holmes@state.co.us*
Independent Medical Exams	(303) 318-8655	*IMEUnit@state.co.us*
Fee Schedule	(303) 318-8667	*christy.culkin@state.co.us*
Utilization Standards	(303) 318-8667	*christy.culkin@state.co.us*
Medical Billing Dispute Resolution	(303) 318-8765	*cdle_medicalpolicy@state.co.us*
Medical Treatment Guidelines	(303) 318-8760	*roy.foster@state.co.us*
Utilization Review Program	(303) 318-8767	*Iliana.gallegos@state.co.us*

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Level I Accreditation Pre-Test

1) A critical document to be completed by the primary treating physician at the opening & closing of a workers' compensation case is:

a) CMS 1500
b) WC164
c) Temporary Total Disability Status form
d) WC30 – Designated Health Care Provider Disclosure Form

2) A physician must complete the initial report with the appropriate form within:

a) 3 days
b) 7 days
c) 10 days
d) 14 days

3) True or False: It is acceptable for a treating medical provider to supply information regarding work restrictions to the patient's work supervisor without a release from the patient.

4) "Temporary Total Disability" is provided to an injured worker:

a) As wage replacement when the worker cannot return to part time or modified duty
b) As a required status before applying for social security disability benefits
c) When it is determined that the worker will never be able to return to his/her previous job
d) When the worker declines to return to work because of pain

5) When a worker returns to employment and receives an impairment rating at the medical termination of the case, the benefits received at that time are called:

a) Temporary Partial Disability
b) Permanent Total Disability
c) Temporary Total Disability
d) Permanent Partial Disability

6) True or False: A copy of the WC 164 form must always be filed by the authorized treating physician with the Division of Workers' Compensation.

7) If an employer is unable to accommodate a claimant's written work restrictions:

a) The employee may seek revised restrictions from another medical provider
b) Temporary Total Benefits may continue
c) MMI can be declared
d) The worker becomes permanently, totally disabled.

8) True or False: The physician must declare the physical or mental impairment as a result of the injury is not reasonably expected to improve with time in order to find a patient at Maximum Medical Improvement.

9) Written work restrictions (check all that apply):

a) Can be applied at the first medical visit
b) Can be applied at the last medical visit
c) Can be sufficiently described as, for example, "Light duty."
d) May be supplied directly to the claimant's employer
e) When assessed, should be considered as unique and separate from the claimant's non-work activities.

10) A provider selected by the patient at the time of injury when the employer has **not** designated a provider is:

a) A medical consultant
b) A temporary medical provider
c) An authorized medical provider
d) A specialist in workers' compensation injuries

11) True or False: MMI may be assessed by a non-accredited physician.

12) Choose all correct answers. MMI:

a) Is the point at which all medical treatment must stop.
b) Is defined in the Workers' Compensation Act.
c) Must be documented on the WC-164 form
d) The point at which every patient must be referred-out for an impairment rating.

13) True or False: When a physician determines permanent medical impairment; chronic pain cannot be given a rating.

14) Upon notification of a worker's injury, the employer in most circumstances must:

a) Provide the worker with a referral to one medical physician or one clinic
b) Allow the worker to see his/her own medical physician as long as that provider is an M.D. or a chiropractor
c) Provide the worker with a list of at least 4 physicians or clinics from which to select a treating physician
d) Require that the worker file his/her own claim for compensation with the DOWC

15) True or False: The possible existence of impairment can be assessed only by a Level II accredited physician at the time of MMI.

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16) Choose all that apply: Once MMI is determined for a patient:

a) Maintenance treatment cannot be performed
b) The physician must complete the date of MMI and work restrictions of the patient, if any work restrictions apply.
c) The Level I Accredited physician must refer patient to a Level II Accredited physician
d) Maintenance treatment, if recommended, must be documented on WC 164 form

17) True or False: An impairment rating examination must be provided for any worker who has permanent alteration of ADLs due to the work related injury.

18) If you forget to indicate the work status of a patient on the WC-164 form

a) Your Level I accreditation will be revoked
b) The insurer may discontinue the patient's disability benefits
c) The insurer may withhold payment of your fees
d) The employer will assume the patient cannot perform his/her job duties and will be terminated

CAUSALITY

19) In the Bradford Hill standards of risk assessment for determining causality, which of the following risk assessment techniques must you apply?

a) Temporal relationship
b) Biological gradient
c) Strength of the association
d) all of the above

20) Ten years ago a worker had a low back injury which required a one-level fusion which became stable. The worker sustains a low back strain at work and presents at your office. All of the following should be performed to determine if the injury is work related EXCEPT:

a) Evaluate and assign a diagnosis
b) Assess the mechanism of the current injury
c) Speak to someone else at the workplace that witnessed the injury or can corroborate the patient's account
d) Identify the patient's job duties

21) True or False: Medically probable is defined as 50% or more probable.

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ETHICS

22) A patient is sent to an IME by the insurer, and you as a treating provider are sent a copy of the IME report along with a cover letter from the insurer's attorney. The claimant's attorney takes issue with the report and the letter from the insurer. Should you ignore the report? Choose the best response:

a) Yes – because it is now a contentious issue between the parties
b) Yes – because it represents the opinion of a doctor hired by the insurer
c) No - it is one medical opinion of possibly many that are relevant to this case
d) Yes – because ethically your primary duty is to the patient

23) True or False: A patient has a history of psychological issues with corresponding records, however the patient has low back pain and no work related psychological issues. Under Colorado law, a treating physician is obligated to surrender copies of these records pertinent to a litigation claim to both parties.

24) As an authorized treating physician, you are required to release patient information to the:

a) nurse case manager
b) employer
c) employer's attorney
d) none of the above without release from patient

25) True or False: When giving opinions about a workers' compensation case, a physician may appropriately be influenced by the insurer's nurse case manager.

26) The Workers' Compensation Act states that "the filing of a claim for compensation is a limited waiver of the doctor-patient relationship privilege to persons who are necessary to resolve the claim." Therefore, it is ethically acceptable for a medical provider to (*choose the best response*):

a) Release all medical records to any party in the case because of the limited waiver provision
b) Agree to privately discuss the patient's case with the insurer's nurse case manager
c) Decline to release any medical records to the non self - insured employer unless the patient provides a signed authorization
d) Release medical records to any party because HIPAA does not apply to the insurer, the employer or their attorneys

27) True or False: In workers' compensation, the written report of an independent medical examiner is supplied only to the party who requested and paid for the exam.

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RULES

28) Revocation of Level I accreditation can be ordered by the Director of the Division of Workers' Compensation when the:

a) DOWC utilization review panel recommends revocation after reviewing a claim
b) Level I physician has five violations of the medical treatment guidelines
c) Level I physician bills for two body parts
d) DOWC utilization review panel recommends that the provider be removed from a specific case

29) True or False: A chiropractor who is NOT Level I accredited and is treating a work-related injury can provide treatment for a case with 4 lost work days.

30) Prior authorization for providing care is needed when:

a) Treatment is within the guidelines
b) Whenever the insurer asks for it
c) Treatment deviates from the guidelines
d) Whenever you assign light duty for this patient

31) True or False: The insurer may be required to pay for costs of services from an authorized treating provider if the patient has sought care for a work related injury with that provider.

32) What percentage of injured workers can be expected to return to full duty employment after six months of being off work?

a) 60%
b) 30%
c) 40%
d) 50%

GUIDELINES

33) According to the Colorado Medical Treatment Guidelines, all of the following are always required for the treatment of chronic pain, **EXCEPT:**

a) a detailed, repeated diagnostic work up
b) a psychological evaluation
c) a review of active therapy with the patient
d) multi -disciplinary care

34) True or False: Your patient has a lumbar strain and must be able to lift 100# in order to return to work. He is making regular progress in physical therapy and is able to now lift 75# but his progress has plateaued the last 2 weeks. You recommend an interdisciplinary program in which the patient can be assessed for continuing progress using weekly decreasing pain score and weekly decreasing use of narcotics.

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35) The injured employee you are treating states he cannot return to work due to pain. As the treating physician, you:

a) Ask the employee what kind of work duty is available and release the employee to a specific job duty
b) Release the employee back to work at light duty status and let the employer decide the work status
c) Objectively determine the employee's physical abilities and release employee to return to work with written physical restrictions
d) Determine the patient's work status of not returning to work due to this subjective reports of pain

36) When filling out the WC-164 form for work status, the report should state the employee:

a) is released to desk duty
b) is released to light duty
c) can lift up to 10 pounds
d) is released to modified duty

37) True or False: A missed diagnosis can cause a prolonged clinical course that could be confused with chronic pain disorder.

BILLING/FEE SCHEDULE

38) The workers' compensation insurance company has scheduled an appointment for a patient. Cancellation fees are appropriate under which of the following circumstances?

a) The patient did not come.
b) The patient re-scheduled within 24 hours of the appointment.
c) The patient cancelled but did not reschedule the day of the appointment.
d) The insurer cancelled the appointment for the patient within 24 hours due to not finding the injury work related.

39) True or False: According to Rule 16, the fee schedule is the maximum allowance for all medical and medically related procedures.

40) When contesting authorization for medical reasons, the payer must submit all EXCEPT:

a) Name and professional credentials of person conducting the review
b) A copy of the medical review, including reference to the Colorado Medical Treatment Guidelines
c) Certificate of mailing within 7 business days
d) The WC-164 form

41) True or False: If the payer fails to respond to a request for prior authorization in a timely manner described in Rule 16, then the procedure should not be completed.

42) If you receive a denial of authorization and you disagree with the medical reasoning of the reviewer, you must respond in writing within:

a) 3 business days
b) 5 business days
c) 7 business days
d) 2 business days

43) True or False: An E&M visit can be billed at each visit with manipulation when the records state manipulation is required three times per week.

44) The following billing form is necessary to complete before submitting the bill for service:

a) CMS 1200
b) CMT 1500
c) CMS 1500
d) WC-164

45) If a calculated permanent impairment rating of a workers' compensation injury is not required, reimbursement for the WC 164 report on maximum medical improvement may be billed:

a) As a two level increase of the office visit code
b) By using the appropriate Division "Z" code for this service
c) As a fee to be calculated at the rate of $150.00/hour
d) None of the above

46) True or False: When providing modalities for treatment, prior authorization is not required for billing more than two different modalities per visit per discipline.

47) Personnel, materials, equipment, space and other facility overhead included in providing service is defined as what type of radiology procedure code?

a) technical component
b) total component
c) total unit value component
d) professional component

48) True or False: When determining the level of E&M office visit, time can be used only when 50% or more time is documented for coordinating care or educating the patient.

49) The limitation on physical medicine procedures is _____ hour (s) per day per _____.

a) one, injury
b) one, discipline
c) two, discipline
d) two, injury

50) Which of the following are criteria for allowing the billing of an E&M office visit?

a) The patient requires counseling on “return to work with limited duties.”
b) Re-evaluation of the patient is necessary to change treatment protocol
c) A significant evaluation of the patient is necessary to determine progress with treatment being provided
d) All of the above

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Level I Accreditation Pre-Test Answers

1) **b**: Rule 16-7 (E)
2) **d**: *14 days*, Rule 16-7 (E)
3) **True** –Detailed medical information should not be given to the employer without authorization from the patient
4) **a**: § 8-42-106 (1), C.R.S. Temporary Total Disability: when a worker is totally restricted from duty or if the employer **cannot** provide suitable accommodated duty (part-time duty, no return to work duty). Keep in mind, termination of temporary total disability can happen if the patient is able to return to modified duty, the physician gives written release to return to regular employment, or the employee fails to return to work on his/her own accord, even if the physician releases them to return to work.
5) **d**: § 8-42-107 C.R.S. Permanent Partial Disability: when an injury results in permanent medical impairment. An impairment rating must be provided for any worker who has a permanent alteration of ADLs due to the work related injury. The benefits are based on the impairment rating of the authorized treating physician who is Level II Accredited. In Colorado, the AMA Guides 3rd revised edition is used to calculate impairment ratings. The claimant who is not satisfied with the authorized treating physician's impairment rating can challenge the impairment rating by paying for a Division Independent Medical Examination (DIME.)
6) **False** – The WC 164 form should be given to the patient and insurer after each visit. If the physician does not respond promptly to a request for verification of the work status of a patient, the insurer may withhold payment of your fees.
7) **b:** § 8-42=105 (1) C.R.S. Temporary Total Benefits continue if the employer cannot accommodate the employee's work restrictions.
8) **False**- Under Colorado Statute, the improvement of a condition over time without additional medical treatment is not considered as part of MMI. MMI exists when the underlying condition causing the disability has become **stable** and no further treatment is reasonably expected to improve the condition.
9) **a, b, d-** Written work restrictions should always be specific to the job duties (i.e.: limit waist level lift to 25 pounds, sitting limited to 20 minutes/hour.)
10) c: Rule 16-2(B)(3): Authorized Treating Physician: The employer has the right in the first instance to select the authorized treating physician. The claimant is presented with a list of at least four physicians, clinics or a combination thereof, from which the worker must choose a primary treating physician. If the employer does not timely designate a list of at least four

providers to the injured worker, 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.

11) **True-** Rule 16-7(E)**:** A non –accredited physician may determine MMI, but if there is permanent impairment, the injured worker must be referred to a Level II accredited physician within 20 days for an impairment rating.

12) **b, c –** Rule 16-7 (E) (b): MMI must be documented on WC 164 form and is defined in the Workers' Compensation Act. Also keep in mind, once a patient is at MMI, maintenance treatment must be documented on the MMI (WC164) form and documentation of any permanent work restrictions. Once the patient is at MMI, payments for temporary disability cease. **IF** the patient has permanent partial disability, then the patient must be referred to a Level II accredited physician for an impairment rating within 20 days of determination of MMI.

13) **False** – A chronic pain rating must be based on objective findings before a rating can be determined

14) **c:** §8-43-404(5)(a)(I)(A) C.R.S., an employer or insurer shall provide a list of at least four physicians or clinics.

15) **False**- Rule 12-2(A): Assessing that there is a probable permanent impairment can be performed by Level I accredited physician or any other physician, however, a Level II accredited physician is only able to perform impairment ratings.

16) **b,d:** Rule 16-7(E) , once MMI is determined, the authorized treating physician should complete the WC-164 form and include work restrictions and maintenance treatment.

17) **True:** Rule 12-2 : When an authorized treating physician determines the injured worker is at MMI and has not returned to his/her pre-injury state, physically and/or mentally, the treating physician shall determine, or cause to be determined, a permanent medical impairment rating.

18) **c:** Rule 16-8(B)(8): Work restrictions must be indicated on WC 164 form or the insurer can withhold payment to the provider.

19) **d:** Found under "Causality" in the Level I Curriculum. According to the Bradford Hill standards for Risk Assessment Method, strength of the association, consistency of the evidence, specificity of the result, temporal relationship, biologic gradient and coherence should be taken into consideration to assess causality.

20) **c:** when determining causality, a detailed description of the employee's job duties and detailed description of the incident reportedly causing the injury are necessary pieces of information. Also, the physician should determine if the patient requires treatment if not for the work-related event.
21) **False** –Medically probable is greater than 50%, see curriculum under "Causality" – steps in causality determination
22) **c:** see Interpretive Bulletin in curriculum: under DOWC Rules section: Keep in mind, the physician may be appropriately influenced by other medical consultant's opinions, but not the insurance company or attorneys.
23) **False**: See Interpretive Bulletin in curriculum: under DOWC Rules section : Detailed psychological information not directly related to the claim should not be given without authorization from the patient. Only information that pertains to the work related injury should be released. Medical providers should follow HIPAA requirements (164.508 (a)(2)), for the protection of psychological records, which require a specific authorization.
24) **d:** a physician must have permission from the patient to release information that is not directly related to the case.
25) **False** – The physician may be influenced by a medical consultant's opinion and no other parties.
26) **c:** §8-47-203: patient must provide signature to release records. Note that the workers' compensation insurers do not follow HIPAA**.** The provider is the last stop for the release of medical records.
27) **False** – Rule 8-10(F): All parties, including the claimant, insurer and their attorneys must receive the report
28) **a:** §8-43-501(3)(c)(III): Revocation of Level I Accreditation can occur if: the DOWC utilization review panel unanimously recommends revocation after reviewing a claim, the physician twice violates the rules or regulations proclaimed by the director, or the physician is continuously non-compliant per statute. The Director can order a retroactive denial of fees based on the recommendations from the utilization review panel.
29) **False**- §8-42-101(3.6)(a)(I): Chiropractors not Level I accredited cannot treat work related injuries with more than 3 days lost time from work, more than 90 days from the time of injury or more than 12 treatments.
30) **c:** Rule 19-9(B): Prior authorization is needed if the service exceeds the recommended limitation set forth in the Medical Treatment Guidelines. If the payer does not respond to the request for prior authorization in a timely manner, the request is deemed authorized for payment.
31) **True** – Rule 16-2(B)(3), §8-43-404: If the employer does not timely designate a list of four providers, a physician may be selected by the injured worker.

32) **d:** Rule 17 (Medical Treatment Guidelines) General Principles #11, 50% of workers out of work 6 months or more never return to work**.**
33) **a:** Rule 17**:** Medical Treatment Guidelines Chronic Pain, (E)(2): psychological evaluation and interdisciplinary care are required for treatment of chronic pain.
34) **False** – Rule 17: Medical Treatment Guidelines General Principle #7: Progress should be measured by functional activities such as increasing the ability to lift a certain weight.
35) **c:** Rule 16-8(B), must provide specific written work restrictions on WC 164 form from your objective findings. It is then up to the employer to determine accommodations for the employee.
36) **c:** §8-42-105&106, Level I Curriculum under "W/C Case Chronology" Due to the possibility of misinterpretation of work restrictions, work restrictions must be specifically stated.
37) **True:** Rule 17- Medical Treatment Guidelines Chronic Pain: (E) A missed diagnosis, along with inappropriate care and psychological factors can prolong the clinical course that could be confused with chronic pain disorder. Inappropriate care can include passive modality-oriented physical therapy.
38) **a:** Rule 18-6(B): A cancellation fee is payable only when a payer schedules an appointment and the injured worker fails to come, and the payer has not canceled three business days prior to the appointment. If the patient does not show for an appointment, the insurer should be notified so they may reschedule the patient.
39) **True:** Rule 16-4 – Fee Schedule sets maximum allowable payment.
40) **d:** Rule 16-10 (B)(3) – Must provide a copy of medical review, including references to the medical treatment guidelines, name and credentials of the provider and certificate of mailing.
41) **False**- Rule 16-10(E): The request is deemed authorized for payment of the procedure if the payer does not respond in a timely manner.
42) **c:** Rule 16-10(C)(1) *7 business days*
43) **False** – Rule 17: Medical Treatment Guidelines: Low Back Pain: Manipulation limits must be followed per the guidelines Rule 18-5(H)(5)(6) An office visit may be billed on the same day as manipulation codes when the documentation meets the E&M requirement and an appropriate modifier is used.
44) **c:** Rule 16-7(B)(1): CMS 1500 shall be used by all providers for billing for professional services

45) **b:** Rule 18-6(F)(3) and Rule 18-6(G)(2)(b): Billing code Z0752 – When a claimant is at MMI without permanent impairment, the ATP completes the closing report WC-164. Rule 18-6(G)(4): Keep in mind, when a variable-content report is requested by the insurer, the physician can submit a narrative report with variable content and charge appropriately.

46) **False** – Rule 18-5(I)(7): Prior authorization is required for billing. Billing Restrictions: There is a total limit of two (2) modalities (whether timed or non-timed) per visit, per discipline, per day.

47) **a:** Rule 18-5(E)(F)(1)(d), Rule 18-5(H)(9)(c) *technical component*; the total value component in radiology comprises the technical component and professional component .

48) **True:** Rule 18-5(J)(1): If 50% of the time spent for an E&M visit is shared decision making, disability counseling or coordination of care, then time can determine the level of E&M service.

49) **b:** Rule 18-5(I)(6): maximum allowed is one hour of procedures per day, per discipline, unless medical necessity is documented and prior authorization is obtained from the payer.

50) **d:** Rule 18-5(J)(1): billing of an E&M visit is applicable if the patient requires counseling on return to work duties, re-evaluation to change treatment protocol or an evaluation to determine treatment progress. If a patient has a scheduled manipulation only, then the office visit cannot be billed.

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Workers' Compensation Case Chronology

Objectives:

- Define an authorized treating physician.
- Discuss the procedure for determining physical restrictions and work status.
- Identify the events that result in discontinuation of temporary disability payments.
- Define Maximum Medical Improvement.
- Define impairment and describe the difference between impairment and disability.
- Explain the process for obtaining an impairment rating when the authorized treating physician is not Level II accredited.

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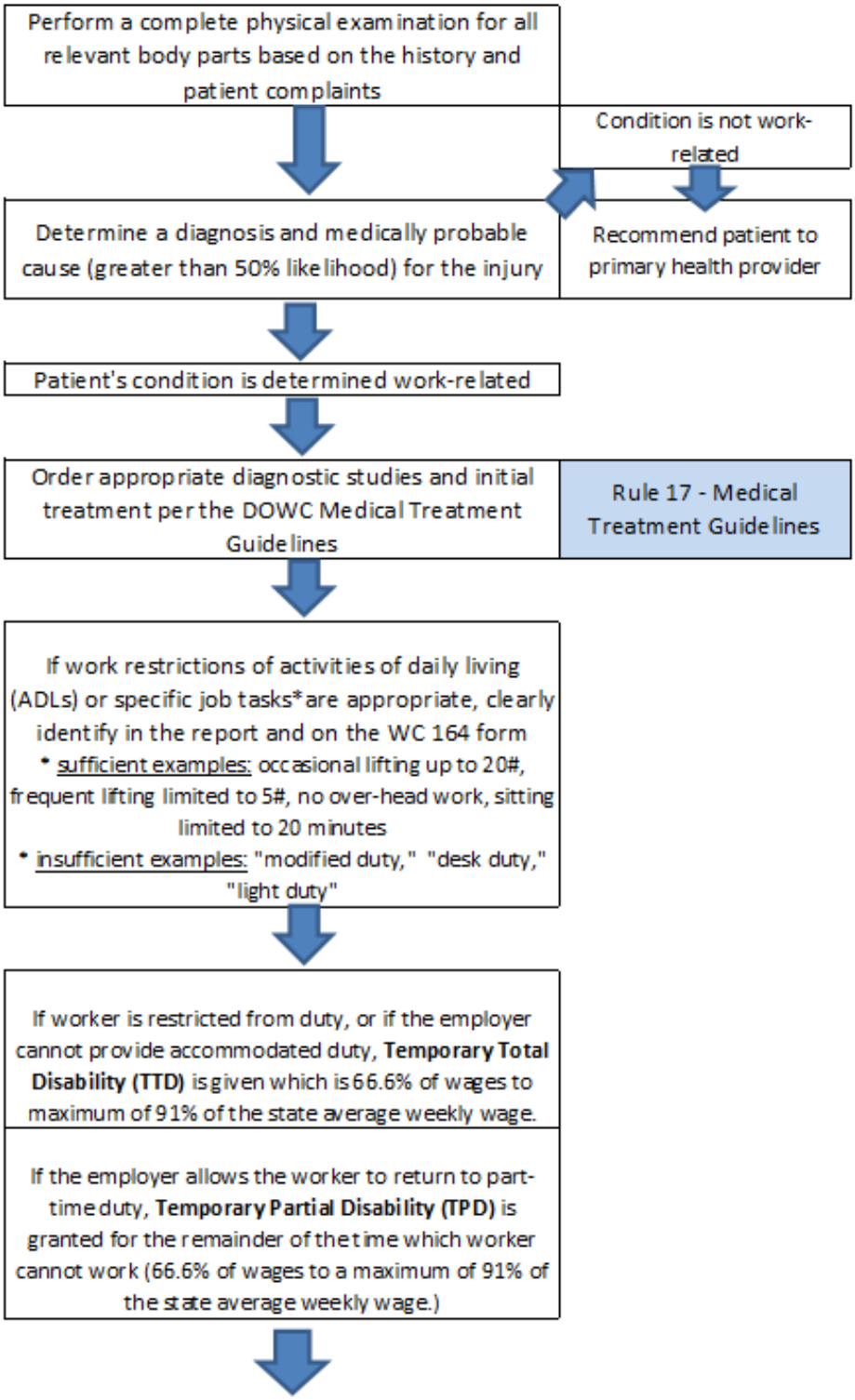
Chronology of a Workers' Compensation Case	Reference to Rule or Statute
Injury occurs at work or worker recognizes symptoms of illness which may be work-related	C.R.S. 8-41-301
Worker reports incident and symptoms to employer	C.R.S. 8-43-102 (1) (a) and (2)
Employer files first report of injury (FROI) form with insurer	C.R.S. 8-43-103 (1)
OR	
Employer does not concur that injury is work related and refuses to file a FROI, worker can file a Workers' Claim with the Division	C.R.S. 8-43-103 (1)
Worker must seek care from a list of four (4) providers* designated by the employer to be the authorized treating physician (ATP) and will remain primary provider throughout the claim. *four clinics, or combination thereof ^if the employer does not timely designate a list of four providers, then the worker may see the physician of his/her choice.	C.R.S. 8-43-404 (5), 8-42-101 (a);(3) (a) (III);(3.6)
If the insurer and patient agree to change providers, the worker can change ATP (not clinic) once or a judge can order a change	C.R.S.8-43-404 (5) (a) (III)
*Chiropractors must be Level I Accredited to treat more than three (3) days lost time, more than 12 treatments, or exceed 90 days of treatment.	C.R.S. 8-42-101 (3) (a) (III)
Responsibilities of a physician at the first visit	
Complete medical history is taken including job duties, mechanism of injury, past medical history, and history of non-occupational activities.	


Perform a complete physical examination for all relevant body parts based on the history and patient complaints
Condition is not work-related
Determine a diagnosis and medically probable cause (greater than 50% likelihood) for the injury
Recommend patient to primary health provider
Patient's condition is determined work-related
Order appropriate diagnostic studies and initial treatment per the DOWC Medical Treatment Guidelines
Rule 17 - Medical Treatment Guidelines
If work restrictions of activities of daily living (ADLs) or specific job tasks* are appropriate, clearly identify in the report and on the WC 164 form
* sufficient examples: occasional lifting up to 20#, frequent lifting limited to 5#, no over-head work, sitting limited to 20 minutes
* insufficient examples: "modified duty," "desk duty," "light duty"
If worker is restricted from duty, or if the employer cannot provide accommodated duty, Temporary Total Disability (TTD) is given which is 66.6% of wages to maximum of 91% of the state average weekly wage.
If the employer allows the worker to return to part-time duty, Temporary Partial Disability (TPD) is granted for the remainder of the time which worker cannot work (66.6% of wages to a maximum of 91% of the state average weekly wage.)

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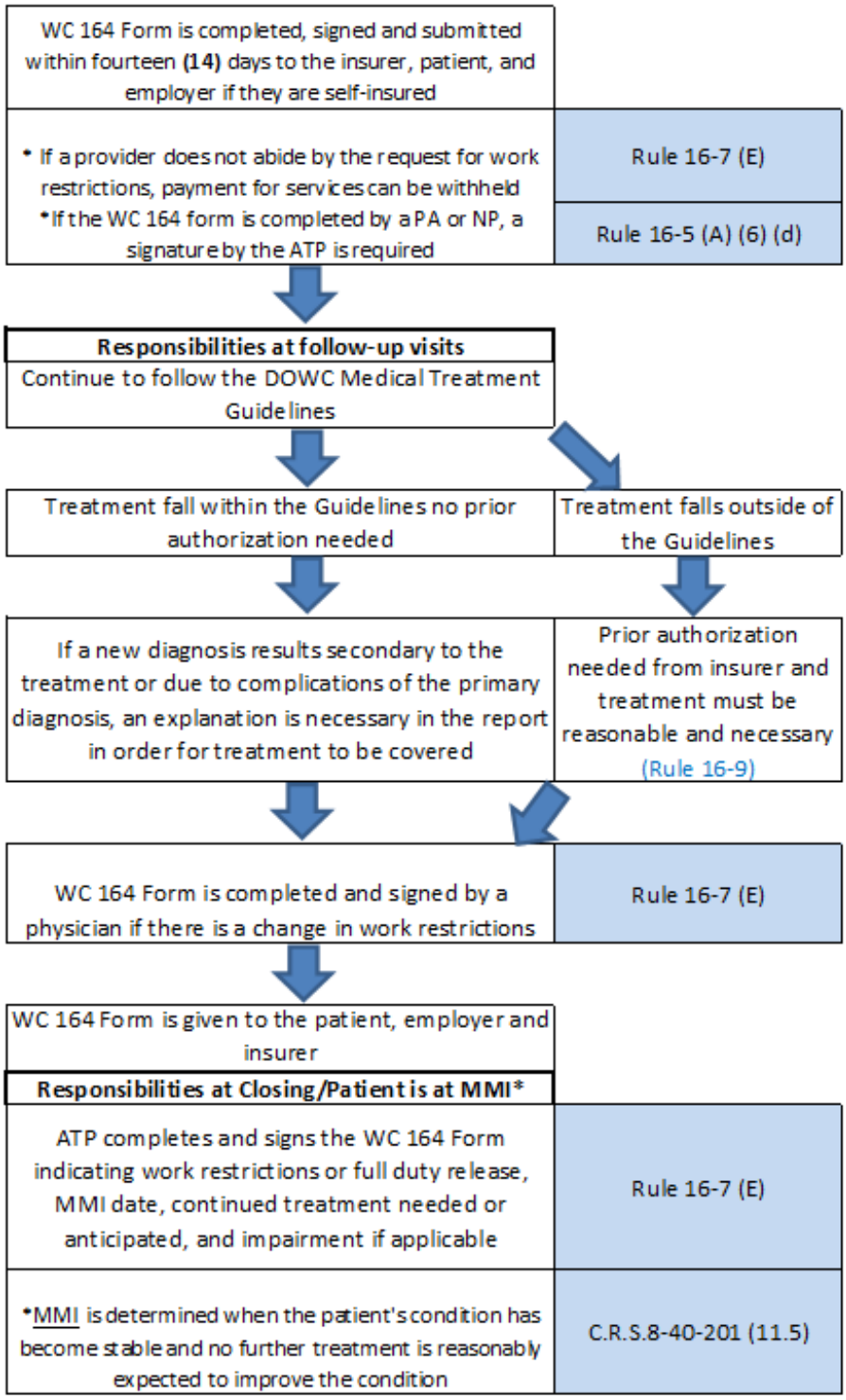

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^Maintenance treatment to sustain the patient's current level of functioning can be prescribed but must be documented	"Grover Meds"; Grover v. Industrial Commission, 759 P.2d 705 (CO 1988)
If the worker is unable to return to full duty, state the permanent physical restrictions in the report and WC 164 Form. If the employer cannot accommodate the permanent restrictions, the worker will not receive further disability payment after the MMI date.	Rule 12-1 and 12-2
If a permanent partial disability impairment rating is warrented, the worker must have a permanent alteration of a body part or system that affects his/her activities of daily living. The *AMA Guides 3rd Edition, Revised*, Rule 12 and the Level II Curriculum must be used to calculate impairment.	C.R.S.8-42-101 (3.7) and 8-42-107 (8) (c)
Patient is given an impairment rating OR referred to a Level II Accredited physician to determine the rating	
Division Independent Medical Examination (DIME) may be requested by insurer or patient to challenge the impairment rating or date of MMI	Rule 11, C.R.S. 8-42-107 (8) (b) (II), 8-42-107.2

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THE WORKERS' COMPENSATION CLAIM PROCESS

Worker reports incident to employer

Employer presents a list of medical providers or clinics for injured worker to choose from (emergency care is handled separately)

Employer files a First Report of Injury with Insurer

Insurer either 'Admits' or 'Denies' the claim. If denial, litigation may follow

With an admitted claim, primary medical provider commences treatment, assesses causality, renders a diagnosis, and determines any work or activity restrictions

Treatment follows Medical Treatment Guidelines

YES

CONTINUE

NO

Prior Authorization Required

Primary provider may refer to other specialists who become authorized in the chain of referral

Conclusion of treatment – provider determines maximum medical improvement (MMI) and permanent impairment, if any

SEE NEXT PAGE FOR CONTINUATION OF CLAIM PROCESS

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THE WORKERS' COMPENSATION CLAIM PROCESS

Conclusion of treatment – provider determines maximum medical improvement (MMI) and permanent impairment, if any

Insurer disagrees with medical conclusions

Insurer agrees with medical conclusions, files a "Final Admission of Liability" (FAL) to legally conclude the case.

Injured worker agrees with Final Admission.

Injured worker disagrees with Final Admission

When dispute is over issues of MMI or impairment, a Division Independent Medical Exam (DIME) must be requested before the parties proceed to a hearing

Workers' Comp Case is settled and concluded

Either party disputes DIME's findings

DIME opinion is rendered.

Both parties accept DIME conclusions

Disputing party may request hearing before an administrative law judge to challenge DIME's opinion

Judge's opinion is not appealed.

Further appeals OR case may be concluded.

(Case can remain open with disputes over non-medical issues)

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IMPAIRMENT

AMA Guides 3rd Revised Edition

Impairment- the loss of, loss of use of, or derangement of any body part, system or function

Disability - limiting, loss or absence of the capacity of an individual to meet personal, social, or occupational demands, or to meet statutory or regulatory requirements (p. 251)

Activities of Daily Living should be permanently affected.

- self-care and hygiene
- communication
- normal living postures
- ambulation
- travel
- non-specialized hand activities
- sexual function
- sleep
- social and recreational activities

Colorado Revised Statute §8-42-101(3.7)

"A 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."

Impairment Rating

- An impairment rating is used to calculate the final payment of the permanent partial disability benefits to the worker.
- If an impairment exists, refer the worker to a Level II accredited physician within 20 days of declaring MMI.
- If the treating physician does not refer the patient for an impairment rating within 20 days, the insurer is required to do so within the following 20 days.

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AMA Guides 3rd Edition, revised, Impairment Rating Tips

Always refer a patient for an impairment rating. If you have assigned permanent work restrictions or the patient now has a permanent change in their ability to perform activities of daily living. For instance, an individual suffered a significant calcaneus fracture and now is unable to hike more than two miles without significant swelling and pain.

1. To receive an impairment for a spinal rating a patient with myofascial findings must first have "a minimum of six months of medically documented pain and rigidity with or without muscle spasm."

2. For extremities any permanent change in range of motion may qualify for a rating.
3. Permanent nerve damage generally qualifies for a rating.

4. The AMA Guides provides for impairment rating based on surgery in many cases.

Isolated Mental Impairment (no physical injury)

Pursuant to C.R.S. §8-41-301(2)(a), mental impairment "…consists of a psychologically traumatic event that is generally outside of a workers' usual experience and would evoke significant symptoms of distress in a worker in similar circumstances. A mental impairment shall not be considered to arise out of and in the course of employment if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, promotion, termination, retirement, or similar action taken in good faith by the employer."

Division Independent Medical Examination (DIME)

A patient or insurer may challenge the impairment rating/MMI date submitted by the authorized treating physician or their consultant by requesting a DIME. Both the insurer and patient must agree upon the DIME panel physician selection. Overall, this process is to decrease the occurrence of litigation.

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Workers' Compensation Low Back Case

PART I

INITIAL VISIT

The following record is the history and physical you obtained on Ed Construct's first visit. (There may be some missing items, but you were very busy that day). Complete the WC164 including your recommendations for treatment. It is not necessary to complete certain items in #2 where no case information is provided.

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ACCU Clinic
Colorado

Patient Name: Ed Construct
Record #: XX
Date of Service: April 12, 2010 – Wednesday

History: This 43 year old white male presents for treatment after a back injury at work two days ago. On Monday he was working with the construction crew on a new department store being built at Park Acres. He was helping secure the placement of a beam when it moved suddenly causing him to twist sharply to the left. He felt an initial sharp pain on the left but continued to work throughout the day. The pain and spasms were worse during the night and Tuesday he could not move without severe back pain. He took Advil and used heat on his back. He contacted the construction company to report the incident and they informed him that they did not have a specific workers' compensation provider. He came to this office because his brother receives treatment here. Pain is in the lumbar region. No numbness or pain in the legs. Some pain in left buttocks. No bowel or bladder problems.

Past Medical Hx: Denies arthritis or any other medical problems – GI, cardiac, endocrine.

Allergies: None

Meds: Advil two tablets q 4h

Family Hx: Mother – HTN, ulcer

Father – angina

Siblings – well

Previous episodes of back pain: Occasional with overuse, takes Advil and then it disappears. Has never sought medical treatment for it.

Hobbies: Softball. Was a football player in high school. Fishing and camping with his male friends. Coaching his sons in Little League.

Social: 1st marriage. Two sons age 8 and 10.

Physical Exam: Ht, 6'2", Wt. 220 lbs B/P 130/82

General – Muscular, somewhat overweight, white male in moderate distress moves hesitantly from chair to examining table.

Back - Palpation – spasm noted bilateral lumbar paravertebral muscles. No significant midline tenderness. Moderately tender left, lateral to midline $L_3 – L_5$.

Range of Motion – Minimal lateral flexion or extension. Anterior flexion approximately 30º.

Straight leg raising – negative for leg pain.

Kemp's Maneuver – pain radiating to the left lower lumbar area

Neurologic Exam:

Reflexes – Achilles 2+ = bilaterally, patellar 2+ = bilaterally

Sensation – intact lower extremities

Motor – 5/5 equal bilaterally toe flexion and extension; foot flexion, extension, eversion, inversion; and leg extension.

AT THIS POINT YOU, AS THE TREATING PHYSICIAN, MUST COMPLETE ANY MISSING TREATMENT PLAN INFORMATION ON THE WC164 FORM

Link to WC 164 form:

https://www.colorado.gov/pacific/sites/default/files/WC164_Physicians_Report_of_Injury_1.pdf

COLORADO [illegible] AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

PHYSICIAN'S REPORT OF WORKER'S COMPENSATION INJURY

A COPY OF THIS REPORT MUST BE SENT TO THE INJURED WORKER AND THE INSURER.

1. REPORT TYPE ☐ Initial ☐ Progress ☐ Closing **EXAM DATE** _____

2. CASE INFORMATION

Date of Injury _____ Insurer Claim # _____
Injured Worker _____ Insurer Name/TPA _____
Social Security # _____ Insurer Phone/Fax _____
Date of Birth _____ Employer Name _____

3. INITIAL VISIT (only)

a. Injured worker's description of accident/injury

b. Are your objective findings consistent with history and/or work-related mechanism of injury/illness? ☐ Yes ☐ No

4. CURRENT WORK STATUS ☐ Working ☐ Not Working

5. WORK-RELATED MEDICAL DIAGNOSIS(ES) _____

6. PLAN OF CARE

a. TREATMENT PLAN

☐ Diagnostic tools/tests _____
☐ Procedures _____
☐ Therapy _____
☐ Medications _____
☐ Supplies _____
☐ Other _____

b. WORK STATUS

☐ Able to return to full duty on _____
☐ Able to return to modified duty from _____ to _____
☐ Unable to work from _____ to _____
☐ Able to return to part time work on _____ for _____ hours per day

c. LIMITATIONS/RESTRICTIONS ☐ No Restrictions ☐ Temporary Restrictions ☐ Permanent Restrictions

☐ Lifting (maximum weight in pounds) _____ lbs.		☐ Walking _____	hours per day
☐ Repetitive lifting _____ lbs.		☐ Standing _____	hours per day
☐ Carrying _____ lbs.		☐ Sitting _____	hours per day
☐ Pushing / Pulling _____ lbs.		☐ Crawling _____	hours per day
☐ Pinching / Gripping _____		☐ Kneeling _____	hours per day
☐ Reaching over head		☐ Squatting _____	hours per day
☐ Reaching away from body		☐ Climbing _____	hours per day

☐ Repetitive Motion Restrictions _____
☐ Other _____

7. FOLLOW UP CARE AND REFERRALS - *7c. requires a notice by certified mail to insurer & patient within 3 business days. (See Instructions)

a. ☐ Return Appointment Date _____

b. ☐ Referral for ☐ Treatment (specify) _____ ☐ Evaluation (specify) _____
☐ Impairment Rating _____ ☐ Other (specify) _____
Referred Provider's Name _____ Phone # _____

c. ☐ Discharged for Non-Compliance* ☐ Discharged from Care for Nonmedical Reasons*

8. MAXIMUM MEDICAL IMPROVEMENT (MMI)

☐ Injured Worker has reached MMI Date of MMI _____
☐ Injured Worker is not at MMI, but is anticipated to be at MMI in/on _____
☐ MMI date unknown at this time because _____

9. MAINTENANCE CARE AFTER MMI ☐ Yes ☐ No
If yes, specify care:

10. PERMANENT MEDICAL IMPAIRMENT (REQUIRED)

☐ No permanent impairment ☐ Permanent Impairment (attached required worksheets and narrative)
☐ Anticipate permanent impairment ☐ Needs referral to Level II physician for impairment rating (see 7b above)

11. PHYSICIAN'S SIGNATURE _____ Date of Report _____

Print Name _____ License # _____ Phone # _____

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PHYSICIAN'S REPORT OF WORKER'S COMPENSATION INJURY
INSTRUCTIONS / DEFINITIONS

This form is required by the Workers' Compensation Rules of Procedure *Rule 16-7(E)(1), 7 CCR 1101-3* to report all information specific to this workers' compensation injury.

Complete all applicable fields and attach your narrative report that further describes and supports your findings. Your narrative report does not replace this form.

1. **Report Type and Exam Date:** Check "Initial" if this is the first visit related to this described injury. Check "Progress" when a change in condition, diagnosis, or treatment occurs. Check "Closing" if the injured worker is at MMI, requires an impairment rating, or is discharged from care. On "Exam Date," include the date of the office visit, if applicable.

2. **Case Information:**
   - **Date of Injury:** Date of this injury.
   - **Injured Worker:** Name of the injured worker.
   - **Social Security #:** The injured worker's social security number.
   - **Date of Birth:** The injured worker's date of birth.
   - **Insurer Claim #:** The name of the insurance carrier or self-insured employer associated with the claim.
   - **Employer Name:** The name of the employer associated with the claim.

3. **Initial Visit:**
   a. Describe how the accident or injury occurred in the injured worker's words.
   b. Check the applicable box regarding physician's objective findings.

4. **Current Work Status:** Current work status as related by injured worker.

5. **Work-Related Medical Diagnosis(es):** State the injured worker's work-related medical diagnosis(es).

6. **Plan of Care:**
   a. **Treatment Plan:** Complete all applicable portions regarding treatment. Indicate frequency and duration.
      - **Diagnostic tools/tests:** EMG, MRI, CT-scan, etc.
      - **Procedures:** Any medical procedure including surgical procedures, castings, etc.
      - **Therapy:** Physical therapy, occupational therapy, home exercise, etc. Include plan specifications.
      - **Medications:** Antibiotics, analgesics, anti-inflammatory drugs, etc.
      - **Supplies:** Durable medical equipment, splints, braces, etc.
      - **Other:** Any treatment not covered above.
   b. **Work Status:** Check the applicable work status box(es). List date(s) and hours as appropriate.
   c. **Limitations/Restrictions:** Check the applicable box(es) regarding any medical or physical limitations or restrictions including temporary or permanent restrictions.

7. **Follow-up Care and Referrals:**
   a. Provide the date of the next scheduled appointment
   b. If a referral was made to another provider, supply that provider's name and phone number. Designate who is to make the referral appointment.
   c. If the authorized physician refuses to provide medical treatment to an injured worker or discharges the injured worker from medical care for nonmedical reasons when the injured worker requires medical treatment to cure and relieve the effects of the work injury, then the physician must, within three (3) business days from the refusal or discharge, provide written notice of the refusal or discharge by certified mail, return receipt requested, to the injured worker and insurer. The notice must explain the reasons for the refusal or discharge and must offer to transfer the injured worker's medical records to any new authorized physician upon receipt of a signed authorization to do so from the injured worker. For a template letter, flowchart, and information on reimbursement, refer to Desk Aid #15 on the Division website.

8. **Maximum Medical Improvement (MMI):** Check the applicable box(es). List additional information as appropriate. MMI means a point in time when any impairment resulting from the injury has become stable and when no further treatment is reasonably expected to improve the condition.

9. **Maintenance Care after MMI:** In some cases, MMI may be unknown because the injured worker has not returned for care.

10. **Permanent Medical Impairment:** Check the applicable box(es). If the injury will cause a permanent impairment, an impairment rating performed by a Level II accredited physician is required. If an impairment rating is given, attach the worksheets required by the Division and a report describing the extent of the injured worker's impairment rating.

11. **Physician Information:** List the name, license number, and telephone number of the physician responsible for the report. **The physician responsible for the report must sign and date the report.**

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WORKERS' COMPENSATION LOW BACK CASE

PART II

CASE FOLLOW UP

The following includes a referral to orthopedics 6 months later with overview of history from time of injury. Only information reflecting changes in care or significant diagnostic testing are included.

You must now complete the WC164 form using the November 1, 2010 visit. Refer to Chronology of a Typical Workers' Compensation Case and associated references for assistance.

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STAR ORTHOPEDICS
COLORADO

Date: October 16, 2010

Patient: Ed Construct

Patient overall is doing well. Initially, had improvement with NSAIDs, physical therapy and manipulation. He has was out of the state on FMLA to care for his dying mother July and August so received no treatment at that time. On his return he strained his back lifting and was referred back to physical therapy for exercise and manipulation. He has had minimal improvement with this more recent strain and is here today for orthopedic opinion. No known depression.

Lumbar spine X-ray on 10/4/10 demonstrated loss of disc height L3-4 and L4-5 with minimal degenerative changes left facets L4-5.

Impression: probable disc desiccation L3-4 and L4-5 with minimal degenerative changes.

Lumbar spine MRI on 10/8/10 which demonstrated normal discs L1-2 and L2-3. Loss of disc height and desiccation at L3-4 and L4-5 with more significant changes at L4-5. No encroachment of nerve roots. Left facets L4-5 with degenerative changes. L5-S1, essentially normal.

Impression: disc desiccation L3-4 and L4-5 with moderate facet degenerative changes left L4-5.

Thank you for referring Ed Construct for an orthopedic evaluation. My findings parallel yours. Mr. Construct has no evidence of any neurologic deficits. He has recurrent lumbar spasms which mostly emanate from some facet pathology at $L_4 – L_5$ and the disc desiccation at $L_4 – L_5$ and $L_3 – L_4$. There is no significant instability of the vertebrae seen on flexion/extension x-rays. Mr. Construct has made some improvement with your conservative treatment and I do not believe surgical intervention would improve this patient's function.

I recommend he continue under your treatment plan. Given the lapse of treatment due to family issues and his functional improvement with the initial treatment, I believe treatment beyond the maximum duration in the guidelines is clearly warranted.

Signed: Dr. Reliable

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ACCU CLINIC
COLORADO

Patient: Ed Construct
Record # XX
Date of Service: November 1, 2010

History: Mr. Construct returns for a recheck. He completed a functional capacity evaluation which demonstrated a lifting limit of 75 lbs. He could not return to his prior job with these lifting restrictions. He has since returned to a new job which involves interior finishing work and has a lifting limit of 75 lbs. This has resulted in some loss of income; however, the patient plans to eventually receive training as an electrician which would increase his salary.

Mr. Construct reports occasional low back pain requiring use of Advil for several days. This is usually brought on by remaining in a static position for too long or engaging in activities such as moving his niece's furniture from her college apartment. The pain may last one to two days. He is continuing his daily exercise program.

Physical Exam:

Range of Motion – appears limited in lateral left flexion and somewhat in extension. Can anterior flex so that fingertips are within 6" of the floor. Right lateral flexion appears normal.

Palpation – Slight tenderness over L_4 – L_5 left lumbar paravertebral muscles. No muscle spasm noted today.

Neurological Exam:

Reflexes - Achilles 2+ = bilaterally, patellar 2+ = bilaterally

Sensation – intact lower extremities

Motor 5/5 equal bilaterally toe flexion and extension; foot flexion,

extension, eversion, inversion; and leg extension

Straight leg raising – no leg symptoms

Kemps' Maneuver – low back pain mid-line only

Impression: – Chronic Low Back Pain

Plan : 1. Patient does not desire any further treatment although a multidisciplinary pain program was offered.

2. Patient at MMI, will complete WC 164

TASK: **Complete the WC 164 using this information**

COLORADO [illegible] AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

PHYSICIAN'S REPORT OF WORKER'S COMPENSATION INJURY

A COPY OF THIS REPORT MUST BE SENT TO THE INJURED WORKER AND THE INSURER.

1. REPORT TYPE ☐ Initial ☐ Progress ☐ Closing **EXAM DATE** _____

2. CASE INFORMATION

Date of Injury _____ Insurer Claim # _____
Injured Worker _____ Insurer Name/TPA _____
Social Security # _____ Insurer Phone/Fax _____
Date of Birth _____ Employer Name _____

3. INITIAL VISIT (only)

a. Injured worker's description of accident/injury

b. Are your objective findings consistent with history and/or work-related mechanism of injury/illness? ☐ Yes ☐ No

4. CURRENT WORK STATUS ☐ Working ☐ Not Working

5. WORK-RELATED MEDICAL DIAGNOSIS(ES) _____

6. PLAN OF CARE

a. TREATMENT PLAN

☐ Diagnostic tools/tests _____
☐ Procedures _____
☐ Therapy _____
☐ Medications _____
☐ Supplies _____
☐ Other _____

b. WORK STATUS

☐ Able to return to full duty on _____
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☐ Reaching over head		☐ Squatting _____	hours per day
☐ Reaching away from body		☐ Climbing _____	hours per day

☐ Repetitive Motion Restrictions _____
☐ Other _____

7. FOLLOW UP CARE AND REFERRALS - *7c. requires a notice by certified mail to insurer & patient within 3 business days. (See Instructions)

a. ☐ Return Appointment Date _____

b. ☐ Referral for ☐ Treatment (specify) _____ ☐ Evaluation (specify) _____
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☐ Injured Worker has reached MMI Date of MMI _____
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10. PERMANENT MEDICAL IMPAIRMENT (REQUIRED)

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☐ Anticipate permanent impairment ☐ Needs referral to Level II physician for impairment rating (see 7b above)

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Print Name _____ License # _____ Phone # _____

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PHYSICIAN'S REPORT OF WORKER'S COMPENSATION INJURY
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   - **Date of Injury:** Date of this injury.
   - **Injured Worker:** Name of the injured worker.
   - **Social Security #:** The injured worker's social security number.
   - **Date of Birth:** The injured worker's date of birth.
   - **Insurer Claim #:** The name of the insurance carrier or self-insured employer associated with the claim.
   - **Employer Name:** The name of the employer associated with the claim.

3. **Initial Visit:**
   a. Describe how the accident or injury occurred in the injured worker's words.
   b. Check the applicable box regarding physician's objective findings.

4. **Current Work Status:** Current work status as related by injured worker.

5. **Work-Related Medical Diagnosis(es):** State the injured worker's work-related medical diagnosis(es).

6. **Plan of Care:**
   a. **Treatment Plan:** Complete all applicable portions regarding treatment. Indicate frequency and duration.
      - **Diagnostic tools/tests:** EMG, MRI, CT-scan, etc.
      - **Procedures:** Any medical procedure including surgical procedures, castings, etc.
      - **Therapy:** Physical therapy, occupational therapy, home exercise, etc. Include plan specifications.
      - **Medications:** Antibiotics, analgesics, anti-inflammatory drugs, etc.
      - **Supplies:** Durable medical equipment, splints, braces, etc.
      - **Other:** Any treatment not covered above.
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7. **Follow-up Care and Referrals:**
   a. Provide the date of the next scheduled appointment
   b. If a referral was made to another provider, supply that provider's name and phone number. Designate who is to make the referral appointment.
   c. If the authorized physician refuses to provide medical treatment to an injured worker or discharges the injured worker from medical care for nonmedical reasons when the injured worker requires medical treatment to cure and relieve the effects of the work injury, then the physician must, within three (3) business days from the refusal or discharge, provide written notice of the refusal or discharge by certified mail, return receipt requested, to the injured worker and insurer. The notice must explain the reasons for the refusal or discharge and must offer to transfer the injured worker's medical records to any new authorized physician upon receipt of a signed authorization to do so from the injured worker. For a template letter, flowchart, and information on reimbursement, refer to Desk Aid #15 on the Division website.

8. **Maximum Medical Improvement (MMI):** Check the applicable box(es). List additional information as appropriate. MMI means a point in time when any impairment resulting from the injury has become stable and when no further treatment is reasonably expected to improve the condition.

9. **Maintenance Care after MMI:** In some cases, MMI may be unknown because the injured worker has not returned for care.

10. **Permanent Medical Impairment:** Check the applicable box(es). If the injury will cause a permanent impairment, an impairment rating performed by a Level II accredited physician is required. If an impairment rating is given, attach the worksheets required by the Division and a report describing the extent of the injured worker's impairment rating.

11. **Physician Information:** List the name, license number, and telephone number of the physician responsible for the report. **The physician responsible for the report must sign and date the report.**

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Elements of a Quality Workers' Compensation Report

1. **Identify patient and referral sources;** e.g., employer referred for first time evaluation, patient referred self without contacting employer, referred by an authorized treating physician.

2. **Specify any additional sources of information reviewed;** e.g., employer job description, x-ray or lab tests, and other medical records.

3. **Record patient's history**
   - Chief complaint
   - Details of accident or exposure
   - Occupation and job duties
   - Current functional status (work related and activities of daily living)
   - Pre-existing injuries, disease and functional status

4. **Record physical exam** - Pertinent negatives are important so be sure to examine related body regions based on mechanism of injury.

5. **Describe behavioral exam when appropriate** - Always assess for signs of depression in patients with chronic pain or delayed recovery.

6. **Note any diagnostic tests** ordered and their results if known.

7. **List diagnoses** – Be specific and use ICD-10 classification. Cumulative trauma or repetitive motion is not a diagnosis!

8. **Discuss work relatedness for each diagnosis.** State your opinion as to the medical probability (greater than 50%) that the diagnosis was caused by a work accident or job duties.

9. **Describe treatment plan -** Include expected functional goals, specific length of treatment and frequency. If treatment is outside of the Colorado Medical Treatment Guidelines justify the necessity for treatment with specific functional goals.

10. **Provide detailed work and activity restrictions.** Factors to consider:
    - Posture - sitting, standing, kneeling, etc.
    - Lifting - specify waist level, overhead, repetitive
    - Repetitive movements – keyboarding, writing, pinching, tool use
    - Hot or cold environments
    - Special tasks - driving, climbing ladders, assembly line work

11. **Describe patient education provided.** Examples:
    - Self- management – e.g. application of heat or cold
    - Exercises
    - Detailed explanation of activity limitation and progression
    - Natural course of condition and expected outcome.

12. **Record expected date of next visit and any specific referrals made.**

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Determining Causality in Workers' Compensation

Objectives:

- Define the Bradford Hill Risk Assessment Method.
- List the principles of risk assessment used to determine causality and apply them to a case.
- Discuss the impact of pre-existing disease or injury on work related injuries.
- List the steps in determining causality determination.

Risk-Assessment or Causal Relationships in everyday life

Wearing a seat belt
Wearing a helmet for bike riding, motorcycles, skiing, horseback riding

Causality Assessment in Medicine

Case #1 55 year old overweight male with HTN presents with severe back pain.
Case #2 25 year old female presents with severe low back pain

Differential diagnosis
Case #1 abdominal aneurysm
Case #2 pelvic pathology

Workers' Compensation Causality

- Alleged relationship between the diagnosis and the work-related exposure.
- Estimate of the risk of developing the diagnosis from the actual work exposure.
- If the relationship has a greater than 50% probability then it is medically probable.

Causation Assessment

1. Record an occupational medical history including a detailed description of the incident reportedly causing the injury or a complete job description of all activities which could have contributed to the patient's symptoms. The

description of job duties should include a list of physical activities required, the duration and frequency of these activities and the total time the individual has worked in the job position. At a minimum, the job activities description should consider specific hand tool use, driving or other skilled activities, approximate lifting estimations, description of the posture required in order to complete the job tasks and consideration of the force necessary for the job tasks.

2. Take a complete medical history including medical diseases past and present, and non-occupational activities which could have affected the complaint. Include hobbies involving the hands for upper extremity complaints and weekend sports activities for musculoskeletal injuries.
3. Establish a differential diagnosis for the patient using the complete history, physical exam findings, and the results of any preliminary diagnostic testing.

4. Assess the medical probability of the relationship between the assumed diagnosis and the work-related exposure.

Case Examples

#1 Mesothelioma in a navy veteran who worked on ships in World War II

Diagnosis is uniformly associated with asbestos exposure

Asbestos exposure was common in this occupation

#2 A worker slips on ice while delivering equipment and complains of medial knee pain.

Diagnosis - possible medial collateral ligament strain

Mechanism of injury – employee is not sure.

#3 Electrician develops carpal tunnel

Risk Assessment Method

To assess causality you must apply traditional risk assessment techniques developed by Bradford-Hill.

1. Strength of the association: The study should show a significant relative risk for developing the disease in question when populations are exposed at a specific exposure level.

2. Consistency of the evidence: Studies with different populations exposed to similar work exposures should produce the same result.

3. Specificity of the result: Studies should be sufficiently controlled to prove that the exposure was the cause of the diagnosis, rather than other confounding exposures or disease entities.

4. Temporal Relationship: The timing of the study and follow-up investigation of the workers should be sufficient to identify the disease in question. Long latency disease studies should exclude those cases occurring too early to be related to the exposure identified in the study.

5. Biological gradient: Studies should show that the greater the exposure, the greater the likelihood of a particular disease or injury. In some cases the phenomenon is “all or none” and no gradient can be present.

6. Coherence: The proposed exposure should be biologically plausible and consistent with previous research. Naturally when an entirely new causal relationship is discovered, initial reports will not necessarily conform with previous literature on the subject.

Workers’ Compensation Statutes

Work related exposure must be the “proximate cause” of the disease or injury.

Proximate cause is defined in Black’s Law Dictionary as the last act “contributory to an injury, without which such injury would not have resulted. The dominant, moving or producing cause.”

Pre-Existing Medical Condition

A pre-existing medical condition which may pre-dispose the worker to an injury does not necessarily mean the case is not work-related. If the worker would not have the injury **without** the work-related event, the injury is most likely also work-related.

Egg shell skull case in legal theory

Case example – Patient with a partial meniscus tear is hit in the leg with heavy equipment and falls, suffering a full thickness meniscus tear.

Physicians should discuss the impact of pre-existing disease or injury on the current work related condition.

Using Risk Assessment

Case example – A worker is exposed to levels of formaldehyde below the OSHA permitted limits.

1. The worker claims to have irritant-induced reactive airway disease.

2. The worker claims the formaldehyde aggravated his pre-existing asthma.

How would you prove or disprove these assertions?

Always answer this question: “Without the work-related exposure or accident, is it medically probable that the patient would have the current diagnosis and require treatment?”

Activities of Daily Living

Generally, if a worker is performing an activity he would normally be expected to perform in day-to-day tasks at home the injury will not be work-related.

Case – An executive suffers a heart attack while reviewing his routine, office e-mail.

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Isolated Mental Impairment (no physical injury)

Pursuant to C.R.S. §8-41-301(2)(a), mental impairment:

". . . means a recognized, permanent disability arising from an accidental injury arising out of and in the course of employment when the accidental injury involves no physical injury and consists of a psychologically traumatic event that is generally outside of a workers' usual experience and would evoke significant symptoms of distress in a worker in similar circumstances. A mental impairment shall not be considered to arise out of and in the course of employment if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, promotion, termination, retirement, or similar action taken in good faith by the employer."

Remember the final determination of work-relatedness rests with the judicial system. This allows consideration of course and scope of duties, enforced safety standards, and location of injury.

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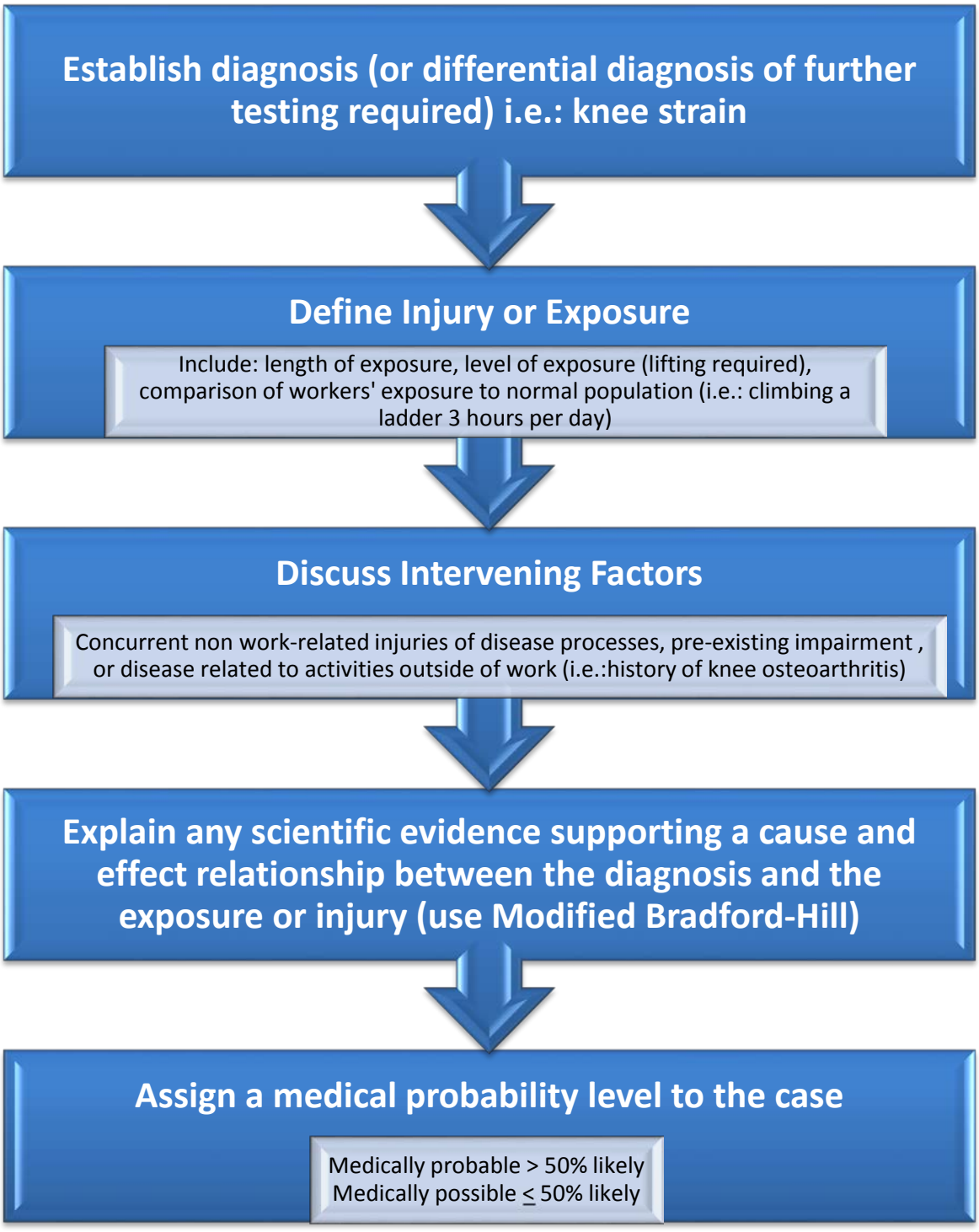
Steps in Causality Determination



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The following pages and tables are reproduced from the Division's *Cumulative Trauma Conditions* medical treatment guideline, eff. March 2, 2017. This information should be used for assessment of causality and diagnoses of disorders involving especially but not exclusively disorders of the upper extremity. The "**Algorithmic Steps for Causation Assessment"** flow-chart applies to causation assessment in general.

e. Physical Examination Findings Reference Table: Specific Musculoskeletal Diagnoses

DIAGNOSIS	SYMPTOMS	SIGNS (Required Findings)
Aggravated Osteoarthritis of the Wrist	Pain usually in the carpometacarpal joints; or in metacarpophalangeal joints.	At least one of the following: Positive grind test resulting in pain; crepitus; Subluxation of the metacarpal may be induced in advanced cases; Swelling; Reduced motion; Angular deformities; Tenderness with palpation of thumb metacarpophalangeal or carpometacarpal joint.
de Quervain's Disease	Tenderness over the first dorsal extensor compartment (anatomical snuff box).	At least one of the following: Pain worsened by resisted thumb abduction and/or extension with or without resistance; Positive Finkelstein's test.
Epicondylitis-Lateral (Epicondylalgia)	Elbow pain over the lateral epicondyle increased with gripping.	Tenderness to palpation at/near lateral epicondyle and pain over the lateral epicondyle and/or extensor mass of the forearm with one of the following maneuvers: Active or resisted wrist extension; Active or resisted middle finger extension; Active or resisted supination.

DIAGNOSIS	SYMPTOMS	SIGNS (Required Findings)
Epicondylitis-Medial (Epicondylalgia)	Elbow pain over the medial epicondyle.	Tenderness to palpation at/near medial epicondyle and pain over the medial epicondyle and/or flexor mass of the forearm with one of the following maneuvers: Active or resisted wrist flexion; Active or resisted pronation.
Extensor Tendon Disorders of the Wrist	Pain localized to the affected tendon(s) worsened by wrist or finger extension.	Pain and/or tenderness with active or resisted wrist/digit extension, specific to the extensor mechanism involved.
Flexor Tendon Disorders of the Wrist	Pain/tenderness localized to affected tendons.	Reproduction of pain with active or resisted wrist/digit flexion or ulnar deviation specific to the flexor mechanism involved.
Triangular Fibrocartilage Complex Tear (TFCC)	Symptoms mainly on ulnar side of the wrist.	Tenderness over the TFCC complex and localized pain, clicking, or findings of abnormal motion with one of the following movements: Forced supination and pronation with axial pressure on an ulnar deviated wrist; The patient pushes up from a seating position using the hand, and/or Ballottement of the distal ulna with the wrist supinated causes abnormal motion as compared to the asymptomatic side.

DIAGNOSIS	SYMPTOMS	SIGNS (Required Findings)
Trigger Finger	Difficulty flexing the finger with a catching or triggering sensation.	One of the following: Tenderness at the A-1 pulley with finger flexion; Triggering of the digit; Difficulty flexing and extending the finger with a palpable nodule.

f. Physical Examination Findings Reference Table: Specific Peripheral Nerve Diagnoses

DIAGNOSIS	SYMPTOMS	SIGNS (Required Findings)
Carpal Tunnel Syndrome	Specific paresthesias in 2 of the following digits: thumb, index, and middle finger. Shaking of the hand (to relieve symptoms) and nocturnal symptoms are common.	At least one of the following: Positive Phalen's sign; Positive Tinel's sign over the carpal tunnel; Positive closed fist test; Positive compression test; Thenar atrophy may be present later in course; Weakness of abductor pollicis brevis; Sensory loss to pinprick, light touch, two-point discrimination or Semmes-Weinstein monofilament tests in a median nerve distribution. No loss of sensation in the central palm.

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DIAGNOSIS	SYMPTOMS	SIGNS (Required Findings)
Cubital Tunnel Syndrome	Paresthesias or dull, aching sensations in the 4th and 5th digits (ring and small fingers) and discomfort near the medial aspect of the elbow.	Paresthesias or dull, aching in the 4th and 5th digits and at least one of the following exam findings: Diminished sensation of the fifth and ulnar half of the ring fingers, which may sometimes include sensory loss to pinprick, light touch, two-point discrimination or Semmes-Weinstein monofilament tests in an ulnar nerve distribution; Positive elbow flexion/ulnar compression test; Later stages manifested by: intrinsic atrophy and ulnar innervated intrinsic weakness; Wartenberg's sign; Froment's sign.
Guyon Canal (Tunnel) Syndrome	Paresthesias in the 4th and 5th digits (ring and small fingers) without proximal ulnar complaints.	At least one of the following exam findings: Positive Tinel's at hook of hamate; Numbness or paresthesias of the palm surface of the ring and small fingers; Decreased strength of the adductor pollicis, abductor digiti minimi, and/or lumbricals.
Posterior Interosseous Nerve Entrapment (PIN)	Weakness of finger and thumb extension	Weakness or inability to extend fingers, thumb or wrist in neutral or ulnar deviation;
Pronator Syndrome	Pain/paresthesias in the median nerve distribution distal to the elbow.	Paresthesias in the median nerve distribution and at least one of the following reproduces median nerve symptoms:

DIAGNOSIS	SYMPTOMS	SIGNS (Required Findings)
Pronator Syndrome, continued		Resisted pronation with elbow flexed at 90 degrees or elbow extended; Positive Tinel's at the proximal edge of the pronator teres muscle over the median nerve.
Radial Tunnel Syndrome	Pain over the lateral posterior forearm. May occur in conjunction with and must be distinguished from lateral epicondylitis. May include paresthesias over the dorsal radial hand and wrist.	The following two elements are required: Tenderness over the radial nerve near the proximal edge of the supinator muscle; Resisted supination or resisted middle finger extension with the forearm pronated and extended reproduces symptoms.

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2. LABORATORY TESTING

Laboratory tests are generally accepted, well-established and widely used procedures. Patients should be carefully screened at the initial exam for signs or symptoms of diabetes, hypothyroidism, arthritis, and related inflammatory diseases. The presence of concurrent disease does not refute work-relatedness of any specific case. This frequently requires laboratory testing. In one study of patients with cumulative trauma conditions (other than carpal tunnel syndrome) who have been seen by specialists, 3% were diagnosed with diabetes, 6% with hypothyroidism, and 9% with a chronic inflammatory disease including spondyloarthropathy, arthritis, and systemic lupus erythematosus. Up to two thirds of the patients were not aware of their concurrent disease. When a patient's history and physical examination suggest infection, metabolic or endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders (e.g., rheumatoid arthritis or ankylosing spondylitis), or problems potentially related to medication (e.g., renal disease and non-steroidal anti-inflammatory medications), then laboratory tests, including, but not limited to the following can provide useful diagnostic information:

a. Thyroid stimulating hormone (TSH) for hypothyroidism;

b. Diabetic screening: recommended for men and women with a BMI over 30, patients with a family history of diabetes, those from high risk ethnic groups, and patients with a previous history of impaired glucose tolerance. There is some evidence that patients with upper extremity disorders are less likely to control their diabetes. Therefore, it is appropriate to order a hemoglobin A1c to screen any diabetic patients with a cumulative trauma condition or for initial screening;

c. Serum protein electrophoresis;

d. Sedimentation rate and C-reactive protein (CRP) are nonspecific but elevated in infection, neoplastic conditions and rheumatoid arthritis. Other screening tests to rule out inflammatory or autoimmune disease may be added when appropriate;

e. Serum calcium, phosphorus, uric acid, alkaline and acid phosphatase for metabolic, endocrine and neo-plastic conditions;

f. Complete blood count (CBC), liver and kidney function profiles for metabolic or endocrine disorders, or for adverse effects of various medications;

g. Bacteriological (microorganism) work-up for wound, blood, and tissue;

h. Serum B6: Routine screening is ***not recommended*** due to the fact that Vitamin B6 supplementation has not been proven to affect the course of carpal tunnel syndrome. However, it may be appropriate for patients on medications that interfere with the effects of Vitamin B6 or for those with significant nutritional problems.

The Division recommends that the workers' compensation carrier cover initial lab diagnostic procedures to ensure that an accurate diagnosis and treatment plan is established. When the authorized treating provider has justification for the test, insurers should cover the costs. Laboratory testing may be required periodically to monitor patients on chronic medications.

3. MEDICAL CAUSATION ASSESSMENT FOR CUMULATIVE TRAUMA CONDITIONS

General Principles of Medical Causation Assessment

The clinician must determine if it is medically probable (greater than 50% likely or more likely than not) that the need for treatment in a case is due to a work-related exposure or injury. Treatment for a work-related condition is covered when: 1) the work exposure causes a new condition; or 2) the work exposure activates or exacerbates a previously asymptomatic latent medical condition; or 3) the work exposure combines with, accelerates, or aggravates a pre-existing symptomatic condition; or 4) the work exposure combines with a pre-existing co-morbid condition, such as diabetes, to render the occurrence of a cumulative trauma condition more probable in combination with the work related exposure. The provider should consider: "Is it medically probable that the patient would need the recommended treatment if the work exposure had not taken place?" If the answer is "yes," then the condition is probably not work-related. In some cases, the clinician may need to order diagnostic testing or job site evaluations to make a judgment on medical probability.

The medical causation assessment for cumulative trauma conditions is not a substitute for a legal determination of causation/compensability by an Administrative Law Judge. Legal causation is based on the totality of medical and non-medical evidence, which may include age, gender, pregnancy, BMI, diabetes, wrist depth/ratio, and other factors based on epidemiologic literature.

The steps in a medical causation assessment for cumulative trauma conditions are:

Step 1: Make a specific and supportable diagnosis. Remember that cumulative trauma, repetitive strain and repetitive motion are not diagnoses. Examples of appropriate diagnoses include: specific tendinopathies, strains, sprains, and mono-neuropathies. Refer to Section F Specific Musculoskeletal Disorders and Section G Specific Peripheral Nerve Disorders for the specific findings of common cumulative trauma conditions. Less common cumulative trauma conditions not listed specifically in these Guidelines are still subject to medical causation assessment.

Step 2: Determine whether the disorder is known to be or is plausibly associated with work. The identification of work-related risk factors is largely based on

comparison of the patient's work tasks with risk factors (as described in Section D.3.a Foundations for Evidence of Occupational Relationships and Section D.3.b Using Risk Factors to Determine Causation).

Step 3: Interview the patient to find out whether risk factors are present in sufficient degree and duration to cause or aggravate the condition. Consider any recent change in the frequency or intensity of occupational or non-occupational tasks. In some cases, a formal job site evaluation may be necessary to quantify the actual ergonomic risks. Refer to Section E.6.c Job Site Evaluations.

Step 4: Complete the required match between the risk factors identified in Section D.3.d Risk Factors Definitions Table and the established diagnosis using the system described in Section D.3.b. Remember that preexisting conditions may be aggravated by, or contribute to, exposures lower than those listed on the table. Those preexisting conditions must be determined by the authorized treating physician based on physiologic plausibility.

Step 5: Determine whether a temporal association exists between the workplace risk factors and the onset or aggravation of symptoms.

Step 6: Identify non-occupational diagnoses, such as rheumatoid arthritis, obesity, diabetes, as well as avocational activities, such as golf and tennis. This information can affect the medical causation assessment. It may be applicable when exposure levels are low and the case does not meet evidence-based criteria.

a. Foundations for Evidence of Occupational Relationships

All results described in this section are a result of a thorough review of the epidemiologic literature available at the time of these Guidelines. One limitation of an epidemiological literature review is that studies rely most heavily upon healthy worker populations and may not reflect the worker population with other concurrent disease or comorbidities. No single epidemiological study fulfills all the criteria for medical causation. Consequently, individual variability lies outside the scope of epidemiological studies and must be addressed by a physician who takes into account not only force, posture, and repetition but also other premorbid risk factors.

The clinician is responsible for documenting specific information regarding the force, posture, repetition, and other risk factors as listed in Section D.3.d Risk Factors Definitions Table. Job title alone is not sufficient to determine the risk factors. A job site evaluation is usually necessary.

Many studies have been completed in industrial settings and focus on cumulative trauma conditions or upper extremity complaints in relationship to work

exposures. The studies vary in several ways that directly affect the interpretation of their results. Studies that provide the strongest evidence have 1) an accepted clinical exam confirming the diagnosis and 2) work exposures validated by direct observation or questionnaires that were correlated with direct observation. Well-done, prospective, longitudinal studies (cohort studies) are preferred. However, for uncommon disorders, these studies may not be able to identify all factors contributing to causation. These Guidelines consider other large prevalence and incidence studies which meet minimum quality criteria and use reliable questionnaires for self-reported exposure.

Many studies report symptoms rather than diseases. These studies are useful for ergonomic research or as pilot studies but do not directly affect the evidence level for causation. They are mentioned, when useful, as indirect evidence. If multiple well-done symptom studies show no increase in symptomatology with specific activities, it follows that there is very little chance that the studied exposure causes disease.

In addition, there are a few studies which address less common musculoskeletal diagnoses or peripheral nerve conditions other than carpal tunnel syndrome, such as posterior interosseous nerve entrapment and pronator syndrome. In these cases, these Guidelines rely upon studies which report the risks for related conditions.

Many of the original studies identifying diagnosable cumulative trauma conditions were performed in manufacturing industries and meat, fish and poultry processing companies. In these industries, most workers are exposed to highly repetitive mono-task jobs which frequently involve a forceful grip, awkward postures, vibration, and cold environments. The evidence for increased disorders when these multiple risk factors are present is compelling. Research attempting to define clear, threshold exposure limits for increased risk from isolated tasks and/or intermittent exposures has less consistent results.

The quality of keyboarding studies is highly variable. Most of the studies rely on self-report. Self-report appears to approximately double the actual time spent using the keyboard. Some studies show distortion highest in the medium range of use. There appears to be less inflation for self-reported mouse use. Fortunately, a few studies have provided more objective keyboard use data.

The group of studies now available provides good evidence that keyboarding in a reasonable ergonomic posture (wrist with 30 degrees or less of extension and 15 degrees or less of radial deviation) up to 7 hours per day under usual conditions is very unlikely to cause carpal tunnel syndrome or other upper extremity disorders. This conclusion is based on studies of carpal tunnel pressure under a variety of typing and wrist positions as well as a number of studies of workers who keyboard on a regular basis. Clinicians may determine in a particular case

that there is a relationship based on the ergonomic conditions or on excessive typing, such as more than 7 hours per day of essentially uninterrupted keyboard use or full-day court reporting.

There is some evidence that mouse use appears to be associated with carpal tunnel syndrome and related symptoms with 4 hours or greater of continuous use per day. Studies of pressure within the carpal tunnel indicated that pressures may rise to levels which could affect the median nerve when the mouse is being dragged or clicked. Again, the actual ergonomics of the work place should be considered for each individual patient before making a final causation decision.

There is a large variety in assessment strategies for lower quality studies. Examples include: 1) symptom only reports; 2) dichotomous choices for exposures, e.g., 1 hour or less per week of repetitive activities versus more than 1 hour per week; 3) self-reported data that does not follow basic pathophysiology, e.g., mouse use between 2.5 and 5 hours per week causing wrist pain; and 4) bias introduced due to prior knowledge of the participants regarding expected work and symptom correlations. In order to reasonably integrate the volume of disparate data, interpretation of lower quality studies took into account reasonable pathophysiology and exposure limits. Dose response relationships were also examined to look for trends in exposure which resulted in increased disease or symptoms.

Most studies were unable to truly assess repetition alone. Indirect evidence from a number of studies supports the conclusion that task repetition up to 6 hours per day unaccompanied by other risk factors is not causally associated with cumulative trauma conditions. Risk factors likely to be associated with specific CTC diagnostic categories include: extreme wrist or elbow postures; force including regular work with hand tools greater than 1 kg or tasks requiring greater than 50% of an individual's voluntary maximal strength; work with vibratory tools at least 2 hours per day; or cold environments.

The variability in study design presented a challenge for creating physiologically reasonable hour limits for the specific primary and secondary risk factors. These Guidelines define risk factor cutoff measures by selecting the strongest studies for specific risks and extrapolating measures. For example, ¾ of a day exposure was translated to a 6 hour exposure. Exposure measures and groups extrapolated in this manner constitute the primary risk factor definitions used in these Guidelines.

Regarding secondary risk factors, the previous version of these Guidelines used a 4 hour exposure cutoff for determining physiologically acceptable limits based on: 1) one study which provides some direct evidence of 4 hours for the most common risks and 2) indirect evidence from other studies, such as one assessing upper extremity functional impairment and another determining the

presence of upper extremity symptoms. Two new studies now suggest that 3 hours is a preferable cutoff for determining physiologically acceptable secondary risks.

No studies examined the relationship between the development of ganglion cysts and work activities. However, work activities, such as bending or twisting of the wrist repetitively, may cause an aggravation of existing ganglion cysts that interferes with function.

Aggravation of a pre-existing medically established diagnosis must be determined on an individual case basis. A comparison of the worker's specific job duties with usual activities of daily living and the occupational risk factors should contribute to the discussion.

Non-occupational exposures

Most studies demonstrate an association of cumulative trauma conditions with older age; high BMI; the presence of other upper extremity musculoskeletal diagnoses; related diseases such as auto-immune conditions, diabetes, hypothyroidism and rheumatologic diseases; and psychosocial issues including relationships with supervisors. The influence of these non-occupational risk factors varies according to the specific diagnoses involved. These additional factors may contribute to the disorder and may impact legal causation, but they do not negate the actual evidence from the defined risk factors supporting a specific work related condition.

Use Section D.3.d Risk Factors Definitions Table and Section D.3.e Diagnosis-Based Risk Factors Table with the following directions to formulate the causation of diagnoses established as cumulative trauma conditions.

b. Using Risk Factors for Medical Causation Assessment of Cumulative Trauma Conditions

The physician should perform the following:

Step 1. Determine the diagnosis.

Using the history, physical examination and supporting studies, a medical diagnosis must be established. Refer to Section F Specific Musculoskeletal Diagnosis and Section G Specific Peripheral Nerve Diagnosis. Less common cumulative trauma conditions not listed specifically in these Guidelines are still subject to medical causation assessment.

Step 2. Clearly define the job duties of the worker.

Do not rely solely on the employer's description of job duties. The worker's description of how they actually perform the duties is extremely important. Job site evaluations are always appropriate, but they are sometimes unnecessary when the physician can identify the job duty that appears to be causing the symptoms and provide a method for ergonomically correcting the activity. Job site evaluations performed to identify risk factors should always include appropriate ergonomic alterations. It may not be possible to recommend ergonomic alterations in industrial settings where the employer is incapable of making changes or ergonomic changes are not feasible.

Step 3. Compare the worker's duties with the Primary Risk Factor Definition Table.

Hours are calculated by adding the total number of hours per day during which the worker is exposed to the defined risk. Breaks, time performing other activities, and inactive time are not included in the total time. When the employee meets the definition for a sole Primary Risk Factor and the risk factor is physiologically related to the diagnosis, it is likely that the worker will meet causation for the cumulative trauma condition. When the Primary Risk Factor identified is not physiologically related to the diagnosis, causation will not be established at this point. The provider then needs to consider Step 4.

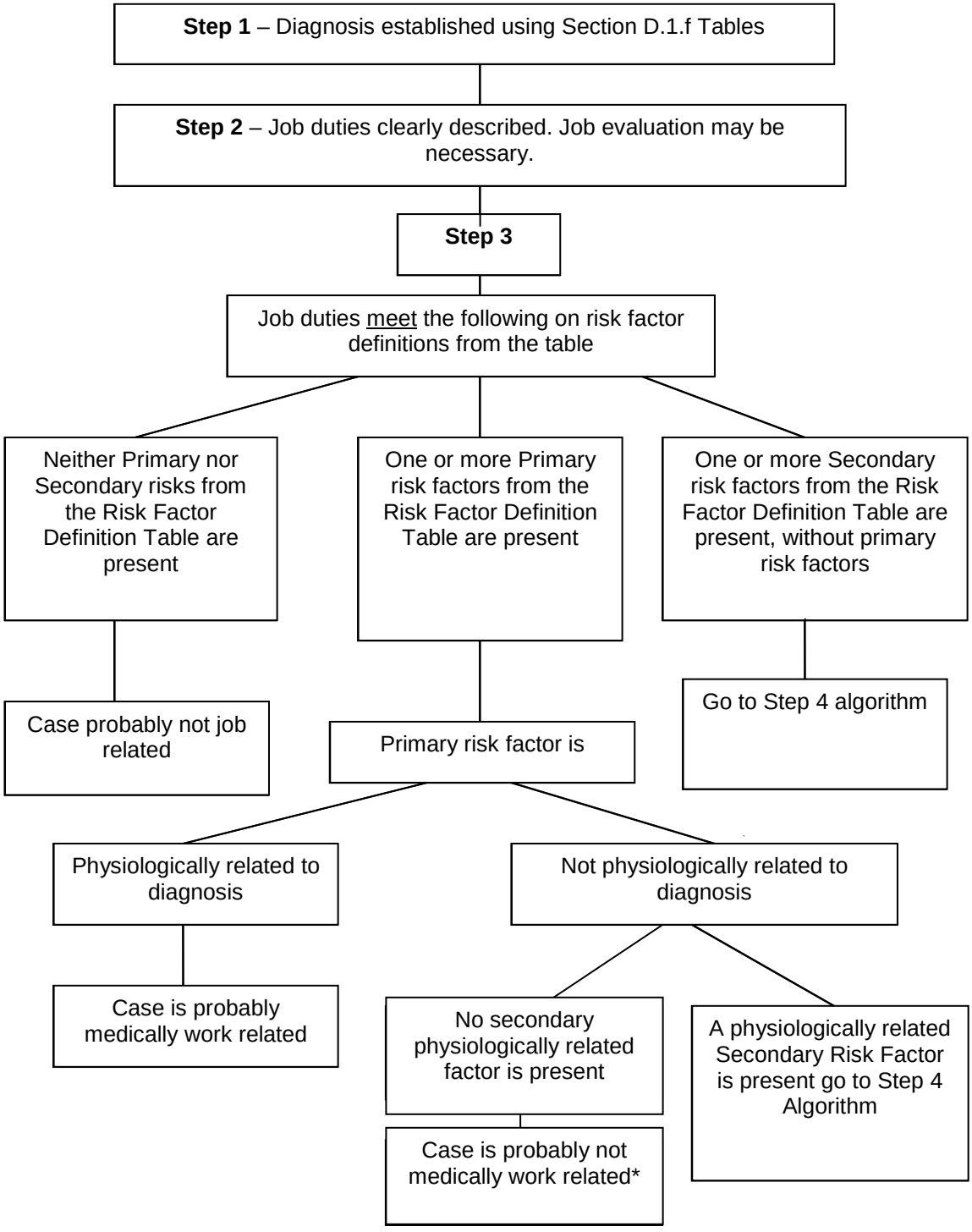
Step 4. Compare the worker's risk factors identified in Step 2 with the Secondary Risk Factor definitions on the Risk Factor Definition Table. If secondary risk factors are identified, proceed to the Diagnosis Based Risk Factor Table.

When no Primary Risk Factors are present but one or more Secondary Risk Factors are found on the Risk Factor Definitions Table, proceed to the Diagnosis Based Risk Factor Table. Elements in this table are listed under the strength of evidence headings. This includes a category for strength of evidence for risks that have been demonstrated not to be related to the diagnosis. Consult the diagnostic category pertaining to the worker. For a number of less common diagnoses, little direct research has been done that meets the quality standards. Therefore, the risk factors for these diagnoses use the risk factors from physiologically related, better researched diagnostic titles. Initially, check the evidence statements for or against causation based on the secondary risks identified previously. If the Diagnosis Based Risk Factor table establishes a match between the Secondary Risk Factor(s) and other job duties using the evidence based columns for the established diagnosis, the case is likely work-related. If none of the evidence categories match

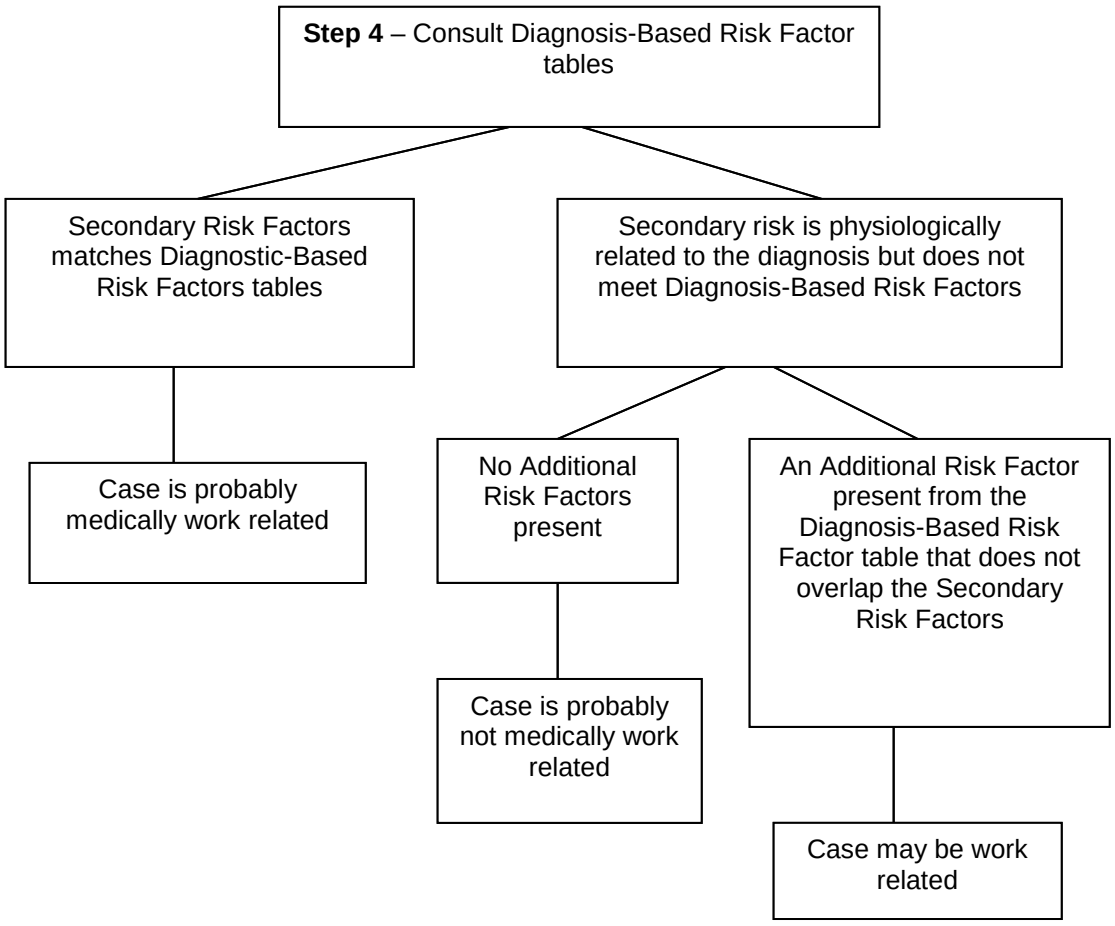
the worker, causation based solely on epidemiological evidence from research has not been established.

Step 5. If an evidence-based medical causation relationship, based on Steps 1-4, has not been established and the worker has one Secondary Risk Factor from Section D.3.d Risk Factors Definitions Table, the physician may consult the last column of Section D.3.e Diagnosis-Based Risk Factors Table entitled “Additional Risk Factors.” This category describes medically accepted physiological risk factors for the diagnosis and risk factors which demonstrated an association with the diagnosis in lower quality studies that did not meet the standards of evidence. Some of the additional risk factors have less clear definitions due to lack of definition in the lower quality studies. These risk factors were added only when the medical professionals on the multi-disciplinary task force agreed they were physiologically plausible. When a Secondary Risk Factor has been identified that does not meet the evidence based definitions Section D.3.e Diagnosis-Based Risk Factors Table, physicians may use the other “Additional Risk Factors,” as appropriate, to establish the presence of combined risk factors. The worker must have met at least one of the Secondary Risk Factor definitions from the Risk Factors Definition Table and that risk factor must be physiologically related to the diagnosis, in order to use the “Additional Risk Factors” in the Diagnosis Based Risk Factor Table. Additional Risk factors that duplicate the conditions in the Secondary Risk Factor identified for the case may not be used. Any conclusions using this methodology are not strictly evidence-based and therefore the physician should include a discussion of why the Additional Risk Factors are pertinent in the particular case.

c. Algorithmic Steps for Medical Causation Assessment



Algorithmic Steps for Medical Causation Assessment continued



*In the case of an aggravation or exacerbation of a pre-existing condition, the provider will need to make an individualized causation decision based on the presence of other accompanying conditions.

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d. Risk Factors Definitions Table

Category	As a Primary Risk Factor	Secondary Risk Factor
Force and Repetition/Duration	6 hrs. of: use of 2 pounds pinch force or 10 pounds hand force 3 times or more per minute.	3 hrs. of: use of 2 pounds pinch force or 10 pounds hand force 3 times or more per minute.
	6 hrs. of: lifting 10 lbs > 60x per hour.	3 hrs. of: lifting 10 lbs > 60x per hour.
	6 hrs. of: use of hand held tools weighing 2 lbs or greater.	3 hrs. of: use of hand held tools weighing 2 lbs or greater.
Awkward Posture and Repetition/Duration	4 hrs. of: Wrist flexion > 45 degrees, extension > 30 degrees, or ulnar deviation > 20 degrees.	
	6 hrs. of: Elbow - flexion > 90 degrees.	3 hrs. of: Elbow - flexion > 90 degrees.
	4 hrs. of: Supination/pronation with task cycles 30 seconds or less or posture is used for at least 50% of a task cycle.	3 hrs. of: Supination/pronation of 45° with power grip or lifting.

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Category	As a Primary Risk Factor	Secondary Risk Factor
Computer Work	Note: Up to 7 hours per day at an ergonomically correct workstation is not a risk factor. Refer to Section H. 6.e Ergonomic Considerations Table for definition of ergonomic risk factors. > 4 hrs. of: Mouse use.	
Use of handheld vibratory power tools and Duration	6 hrs. for more common types of vibration exposure.	2 hrs. when accompanied by other risks.
Cold Working Environment		Ambient temperature of 45F or less for 4 hrs. or more, such as handling frozen foods that are 10 degrees. This risk factor does not stand alone. It is used in combination with other secondary risk factors. Refer to the following Diagnostic-Based Risk Factors Table.

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e. Diagnosis-Based Risk Factors Table

DIAGNOSIS-BASED RISK FACTORS

Hours are calculated by totaling the cumulative exposure time to the risk over an 8 hour day. Breaks or periods of inactivity or performing other types of work tasks are not included. Unless the hours are specifically stated below, "combination" of factors described below uses the Secondary Risk Factor Definitions from the Risk Factor Definition Table.

Diagnosis	Evidence FOR Specific Risk Factors			Evidence AGAINST Specific Risk Factors	Non-Evidence-Based Additional Risk Factors to Consider. These factors must be present for at least 4 hours of the work day, and may not overlap evidence risk factors.[1]
	Strong Multiple high quality studies	**Good** One high quality study or multiple adequate studies	**Some** One adequate study		
Aggravated Osteoarthritis of the Thumb, Carpometacarpal (CMC) and Wrist	No Quality Evidence Available				Work studies support repetitive thumb movement 20 times per minute in women contributing to CMC arthritis. Awkward Posture (depending on the joint involved). Repetition of activities affecting the joint involved for 4 hrs. Prior Injury.
Carpal Tunnel Syndrome		Combination of force, repetition, and vibration.[2,4]	Wrist bending or awkward posture for 4 hrs.		High repetition defined as task cycle times of less than 30 seconds or performing the same task for more than 50% of the total cycle time.[5]

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Diagnosis	Evidence FOR Specific Risk Factors			Evidence AGAINST Specific Risk Factors	**Non-Evidence-Based Additional Risk Factors to Consider.** These factors must be present for at least 4 hours of the work day, and may not overlap evidence risk factors.[1]
	Strong Multiple high quality studies	**Good** One high quality study or multiple adequate studies	**Some** One adequate study		
Carpal Tunnel Syndrome, continued		Combination of repetition and force for 6 hours. Combination repetition and forceful tool use with awkward posture for 6 hours. Combination force, repetition, and awkward posture. Combination of 2 pound pinch or 10 pound hand force 3 times or more per minute for 3 hours.	Mouse use more than 4 hours. Combination cold and forceful repetition for 6 hours - Frozen food handling.	Good evidence - Keyboarding less than or equal to 7 hrs. in good ergonomic position IS NOT RELATED. Good evidence- Repetition alone less than or equal to 6 hrs. IS NOT RELATED.	Tasks using a hand grip. Extreme wrist radial/ulnar positions or elbows in awkward postures.
Cubital Tunnel Syndrome			Combination forceful tool use, repetition and probably posture for 6 hrs- Holding a tool in position with repetition.		Wrist bending and/or full elbow flexion/extension, repetition for 4 hours, vibration.[3] Repetitive pronation of forearm.[3] Sustained pressure at the cubital tunnel.

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Diagnosis	Evidence FOR Specific Risk Factors			Evidence AGAINST Specific Risk Factors	Non-Evidence-Based Additional Risk Factors to Consider. These factors must be present for at least 4 hours of the work day, and may not overlap evidence risk factors.[1]
	Strong Multiple high quality studies	**Good** One high quality study or multiple adequate studies	**Some** One adequate study		
DeQuervain's Disease		Combination force, repetition, & posture.[2,4]			Wrist in ulnar deviation.[3] Repetitive thumb abduction and extension.[3] Wrist bending in extreme postures.[3] Precise hand motions e.g., dental hygienists. Repetitive hitting.
Epicondylitis Lateral		Combination – awkward posture (forearm supination past 45 degrees) and forceful lifting.[2] Combination force and possible awkward posture – study used repetition and turning and screwing. Combination forearm pronation 45° or greater with power grip or lifting for 3 hours per day.	Combination of wrist bending for 4 hours and rotation the forearm for 2 hours. Combination repetition and awkward posture including static posture.	Some evidence keyboard use IS NOT RELATED.	Wrist posture in extension and repetitive supination of the forearm and/or elbow extension.[3]

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Diagnosis	Evidence FOR Specific Risk Factors			Evidence AGAINST Specific Risk Factors	**Non-Evidence-Based Additional Risk Factors to Consider.** These factors must be present for at least 4 hours of the work day, and may not overlap evidence risk factors.[1]
	Strong Multiple high quality studies	**Good** One high quality study or multiple adequate studies	**Some** One adequate study		
Epicondylitis Medial		Combination – force & repetition,[4] force and wrist and hand repetition.	Combination of wrist bending for 4 hours and rotation the forearm for 2 hours.	Some evidence keyboard use IS NOT RELATED.	Wrist posture in flex and repetitive pronation and/or elbow extension.[3]
Extensor tendon disorders of the Wrist		Combination - force & repetition,[4] force and wrist and hand repetition.[2] Combination - forceful exertion and repetition 6 hours. Combination force, repetition, & posture.[2, 4]			Sustained tool use. Awkward posture.[3] No relationship to keyboard use is expected in a good ergonomic workstation. Wrist bending in extreme postures.[3] Repetitive hitting.
Flexor tendon disorders of the Wrist		Combination force, repetition, & posture.[2, 4]			Sustained tool use. Awkward posture.[3] No relationship to keyboard use is expected in a good ergonomic workstation. Wrist bending in extreme postures.[3] Repetitive hitting.

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Diagnosis	Evidence FOR Specific Risk Factors			Evidence AGAINST Specific Risk Factors	Non-Evidence-Based Additional Risk Factors to Consider. These factors must be present for at least 4 hours of the work day, and may not overlap evidence risk factors.[1]
	Strong Multiple high quality studies	**Good** One high quality study or multiple adequate studies	**Some** One adequate study		
Guyon Canal	No Quality Evidence Available.				Ulnar wrist posture and flexion. Direct pressure on the wrist.
Posterior Interroseous Nerve Entrapment	Refer to lateral epicondylitis section above for indirect evidence. No specific evidence available.				Ulnar wrist posture and flexion. Direct pressure on the wrist.
Pronator Syndrome	Refer to medial epicondylitis section above for indirect evidence. No specific evidence available.				Ulnar wrist posture and flexion. Direct pressure on the wrist.
Trigger Finger			Hand tool use – 6 hours.		Repeated digital flexion.
Radial Tunnel Syndrome			Repetition and force - force of 1 kg with cycle time < 1 minute or awkward posture (static posture) elbow > 90 degrees.		Repetitive Supination. Extension of the elbow from 0 to 45 degrees.

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Diagnosis	Evidence FOR Specific Risk Factors			Evidence AGAINST Specific Risk Factors	Non-Evidence-Based Additional Risk Factors to Consider. These factors must be present for at least 4 hours of the work day, and may not overlap evidence risk factors.[1]
	Strong Multiple high quality studies	**Good** One high quality study or multiple adequate studies	**Some** One adequate study		
Triangular Fibrocartilage Compression	No Quality Evidence Available.				Usually from traumatic hyperextension which may become symptomatic over time. Wrist posture in extension and repetitive supination of the forearm and/or elbow extension. For occupational, usually unilateral with ulnar wrist pain while supinating and extending the wrist as part of the regular work duty.

1. Physiological risk factors are those generally agreed upon by the medical community to cause the specific condition described. Other risk factors described are those identified in lower quality studies that are possibly related. These are consensus risk factors.

2. Combined factors refer to the Secondary Risk Factor definitions found in the Risk Factor Definition Table.

3. Caution: These additional risk categories may not be used when awkward posture, using a similar definition, has been cited as a Secondary Risk Factor.

4. Evidence rated as strong by National Institute for Occupational Safety and Health (NIOSH) 1997 criteria are placed in the “good” category because the NIOSH strong evidence definition matches the Colorado “good” level of evidence requiring multiple adequate studies.

5. Due to small case size and a definition of low force/high repetition jobs that likely included many jobs qualifying for a force risk from the “Risk Definitions” table, this study does not support repetition as a sole risk factor.

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Work-Related Workshop Cases 1-3

#1

Chief Complaint: Right elbow pain

History: Forty-five year old male works in meat packing factory where he uses a deboning instrument. He has been employed in this position for two years. The instrument requires him to place his wrist in a dorsiflexed position while rotating his forearm in order to remove the bones. The force for this has been calculated at 4 kg. This usually takes less than one minute. He normally completes an 8 hour day, sometimes with overtime in a freezer/cold environment, working on a regular basis with only two coffee breaks and one meal break during his shift.

The patient is currently experiencing severe medial epicondyle pain to the extent that he did not go to work yesterday due to the pain. He finds that grasping or picking up any object increases the pain significantly. He has tried Advil and ice but this has not significantly changed his complaints. He also reports that in the past he has occasionally noted numbness in the 5th finger and the ring finger. Currently the tingling is not present but whenever he attempts to use the forearm it seems to come back.

Review of Systems: History of hypothyroidism; on Synthroid

Past Musculoskeletal History: Right hand carpal tunnel at least three years ago. No complaints now.

Meds: Synthroid, over the counter Aleve – 3 times per day.

Hobbies: No crafts or musical instruments. Plays golf 2 to 3 times per week but has not engaged in this since the injury.

Family Medical History: Father disabled from WWII post -traumatic stress disorder, no arthritis in the family. Siblings and Mother no disease known.

Family Situation: Divorced for one year with two children, a boy 14 and a girl 12. Patient has custody of these children.

Physical Examination:

Cervical exam - Normal range of motion, non-tender to palpation.

Right elbow - Tender to palpation medial epicondyle, lateral epicondyle non-tender.

Pain with pronation and wrist palmar flexion against resistance. No pain with supination against resistance. Full range of motion non-tender.

Tinel's: Positive for the right ulnar nerve at the elbow, and negative Tinel's for right median nerve

Sensation - 2 point intact.

Grip Strength - Slight decrease on the right secondary to pain. Wrist dorsiflexion, finger abduction and finger opposition are all 5/5 with pain associated with dorsiflexion of the wrist only.

Reflexes - 2+ biceps brachioradialis and triceps bilaterally.

Spurling's - Negative

Thoracic outlet testing - Negative

Impression:

Work-related – yes or no and why.

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Work Relatedness Cases

#2

Chief Complaint: Right elbow pain

History: Forty-five year old right handed administrative secretary for the Health Sciences Center experiencing right elbow pain over the last three weeks. She recalls spending two days copying and assembling heavy conference notebooks immediately prior to the onset of this pain. She used her upper extremities for at least four hours relatively continuously. Following that she transported the books and handed them out at a conference being put on by her department. She now has trouble using her mouse and experiences pain in the elbow with any lifting such as with groceries. Occasionally she notes tingling into the fourth and fifth fingers. This occurs at night or after any lifting or repetitive activity with the elbow. She is able to sleep through the night.

Job Duties: Varies, usually 2 to 4 hours per day of keyboarding but can be up to 8 hours depending upon the boss' requirements. During the two days prior to the conference she was using her right hand to put materials in the 100 ring binders and lifting them into the mailing containers with her right hand.

Review of Systems: History of hypothyroidism on Synthroid

Past Musculoskeletal History: Right hand carpal tunnel at least three years ago. No complaints now.

Meds: Synthroid 0.125 mg, over the counter Aleve – 3 times per day.

Hobbies: No crafts or musical instruments. Plays golf 2 to 3 times per week but has not engaged in this since this injury.

Family Medical History: Father disabled from WWII, post -traumatic stress disorder. No arthritis in family. Siblings and Mother no disease known.

Family Situation: Divorced for one year with two children, a boy 14 and a girl 12. Patient has full custody of her children.

Physical Examination:

Cervical exam – Normal range of motion, non-tender to palpation.

Right elbow – Medial epicondyle, tender to palpation, lateral epicondyle non-tender. Pain with pronation and wrist palmer flexion against resistance. No pain with supination against resistance. Full range of motion without tenderness. Tenderness with palpation of the ulnar forearm muscles.

Physical Examination (Cont'd)

Tinel's positive for the right ulnar nerve at the elbow, and negative Tinel's for right median nerve.

Sensation -2 point intact

Grip strength – Slight decrease on the right secondary to pain. Wrist dorsiflexion, finger abduction, finger opposition and biceps are all 5/5 without difficulty.

Reflexes - 2+ biceps, brachioradialis and triceps bilaterally.

Spurling's - Negative

Thoracic outlet testing - Negative

Impression:

Work-related – yes or no and why.

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Work Relatedness Case

#3

Chief Complaint: Right elbow pain

History : Forty-five year old right handed administrative secretary for the Health Sciences Center experiencing right elbow pain over the last three weeks. She recalls spending two days copying and assembling heavy conference notebooks immediately prior to the onset of this pain. She used her upper extremities for at least four hours relatively continuously. Following that she transported the books and handed them out at a conference being put on by her department. She now has trouble using her mouse and experiences pain in the elbow with any lifting such as with groceries. Occasionally she notes tingling into the fourth and fifth fingers. This occurs at night or after any lifting or repetitive activity with the elbow. She is able to sleep through the night.

Job Duties: Varies, usually 2 to 4 hours per day of keyboarding but can be up to 8 hours depending upon the boss' requirements. During the two days prior to the conference she was using her right hand to put materials in the 100 ring binders and lifting them into the mailing containers with her right hand.

Review of Systems: History of hypothyroidism on Synthroid

Past Musculoskeletal History: Right hand carpal tunnel at least three years ago. No complaints now.

Meds: Synthroid 0.125 mg, over the counter Aleve – 3 times per day.

Hobbies: No crafts or musical instruments. Plays golf 2 to 3 times per week but has not engaged in this since this injury.

Family Medical History: Father disabled from WWII, post -traumatic stress disorder. No arthritis in family. Siblings and Mother no disease known.

Family Situation: Divorced for one year with two children, a boy 14 and a girl 12. Patient has full custody of her children.

Physical Examination:

Cervical exam – Normal range of motion, non-tender to palpation.

Right elbow – Full range motion of the right elbow and full range of motion against resistance including supination, pronation, wrist dorsiflexion, flexion and extension without any complaints of pain.

Work Relatedness Case No. 3 (Cont'd)

Physical Examination (Cont'd)

Palpation of the elbow - The patient reports pain throughout the elbow in all areas. It is not clear that it is more painful over one epicondyle more than the other. There is no swelling or erythema noted.

Right forearm - No tenderness is noted of any of the forearm muscles on palpation.

Right wrist – Full range of motion non-tender.

Right shoulder – Full range of motion.

Tinel's: negative both median nerve and ulnar nerve – right arm.

Sensation - 2 point and intact in all five digits – right hand

Reflexes – 2+ and equal bilaterally biceps, triceps, brachioradialis.

Grip strength – Strong and equal on the right and left side.

Spurling's - Negative

Thoracic outlet testing - Negative

Impression:

Work-related – yes or no and why.

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DOWC Rules

Objectives:

- Review the procedures for release of medical records in workers' compensation cases.
- Describe the accreditation process for medical providers.
- Discuss utilization standards in the workers' compensation system.
- Identify standards of documentation for reimbursement.

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The "Must Know" Rules for Providers in Workers' Compensation

Authorized Treating Physician (Rule 16-2): may be any of the following:

(1) The treating physician designated by the employer and selected by the injured worker;

(2) Change of physician (Rule 8-5(A)): Within ninety (90) days following the date of injury, but before reaching maximum medical improvement, an injured worker may request a one-time change of authorized treating physician pursuant to §8-43-404(5) (a)

- The new physician must be a physician on the designated provider list or provide medical services for a designated corporate medical provider on the list.

(3) A health care provider to whom an authorized treating physician refers the injured worker for treatment, consultation, or impairment rating;

(4) A physician selected by the injured worker when the injured worker has the right to select a provider; Injured worker has the right to select from a list of four providers [C.R.S. 8-43-404(5) (a) (I) (A).] If there are fewer than four physicians or corporate medical providers within thirty miles of the employer's place of business who are willing to treat an injured employee, the employer or insurer may instead designate one physician or one corporate medical provider. [C.R.S.8-43-414(5)(I)(B)]

(5) A physician authorized by the employer when the employer has the right or obligation to make such an authorization;

(6) The injured worker may select a provider when the employer fails to designate a physician;

(7) A health care provider determined by the Director or an administrative law judge to be an ATP;

(8) A provider who is designated by the agreement of the injured worker and the payer. Per statute, an employee may request a personal physician or chiropractor to become ATP providing primary care. If this occurs, the initial ATPs work restrictions continue unless changed by the new ATP.

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Accreditation of Physicians C.R.S. 8-42-101(3.5) – must re-accredit every three years

Level I- MDs, DOs, Chiropractors, Dentists, Podiatrists, PAs
Level II – required to perform impairment ratings: MDs, DOs, Chiropractors – Must be Level I Accredited to treat more than three days lost time, require more than 12 treatments, or exceed 90 days of treatment. C.R.S.8-42-101-(3)(a)(III)

Revocation of Accreditation: C.R.S. 42-101(3) (g) - can occur if:

- Provider fails to comply with rules or statutes
- Misrepresentation
- Recommended by Utilization Review Panel

Medical Utilization Review: (Rule 10-1)

- Formal review of medical services provided by the physician from the Divisions' Medical Review Panel
- A party shall request a utilization review by filing the Request for Utilization Form (request form) with the Division
- Panel consists of 3 providers (Rule 10-6), usually 2 providers from the same as the provider being reviewed and one occupational medicine specialist.
- (Rule 10-8) Outcomes from the review include:
    - Removal of the provider from the case: majority vote
    - Denial of payment: unanimous vote
    - Revocation of accreditation: unanimous vote

Notification Process (WC 195 form): Notification to Payer for Treatment Consistent with the Medical Treatment Guidelines

WC 195 form is used by authorized treating providers for submission to the insurer:

- To indicate that the medically necessary treatment/services falls within the medical treatment guidelines.
- Admission of liability: that the treatment is related to the admitted injury or included in the settled claim and receive a guarantee of payment
- To be used for claim eligibility verification
    - A telephone call may also be used instead of the WC 195 form.
    - The insurer has five (5) days to review the case and contest

The form requires the use of the medical treatment guidelines by justifying the location of the treatment in the guidelines.

Prior Authorization (Rule 16-9) WC-188 form:

Required if:

- The prescribed service falls outside of the medical treatment guidelines
- Procedures that are not identified in the Fee Schedule (Rule 18)

If the provider fails to request prior authorization, it is still payable if reasonable and medically necessary.

Contesting a Request for Prior Authorization: (Rule 16-10):

If the payer contests a request for prior authorization for non-medical reasons as defined under section 16-11(B)(1), the payer shall notify the provider and parties, in writing, of the basis for the contest within seven (7) business days from receipt of the provider's completed request as defined in section 16-9(F).

If the payer is contesting a request for prior authorization for medical reasons, the payer shall, within seven (7) business days of the completed request:

(1) Have all the submitted documentation under section 16-9(F) reviewed by a physician or other health care professional, as defined in section 16-5(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. The physicians or chiropractors performing this review shall be Level I or Level II accredited.

(2) After reviewing all the submitted documentation, the reviewing provider may call the requesting provider to expedite communication and processing of prior authorization requests. However, the written contest or approval still needs to be completed within the specified seven (7) business days under section 16-10(B).

(3) Furnish the provider and the parties with a written contest that sets forth the following information:

(a) An explanation of the specific medical reasons for the contest, including the name and professional credentials of the person performing the medical review and a copy of the medical reviewer's opinion;

(b) The specific cite from the Medical Treatment Guidelines exhibits to Rule 17, when applicable;

(c) Identification of the information deemed most likely to influence the reconsideration of the contest when applicable; and

(d) A certificate of mailing to the provider and parties. The physician has seven (7) business days to provide a written response to the payer

If the payer fails to respond in seven (7) business days, the request is deemed authorized.

If before or after conducting a review pursuant to section 16-11(D)(2), the payer agrees with the billing party's response, the billed service is due and payable in accordance with the Medical Fee Schedule within 30 days after receipt of the billing party's response. Date of receipt may be established by the payer's date stamp or electronic acknowledgement date; otherwise, receipt is presumed to occur three (3) business days after the date the response was mailed to the payer's correct address.

If treatment clearly meets the indications in the medical treatment guidelines and the diagnosis is accepted by the insurer, the treatment should be authorized. Failure to do so could result in penalties against the insurer or loss of accreditation by the physician.

Dispute Resolution: (Rule 16-11(E))- WC 181: the Division can help with disputes regarding:

- Medical bills
- Non-payment issues
- Prior authorizations
- Balance billing issues, and
- Failure to submit timely DIME reports

- If the Division determines there is cause for facilitating the disputed items, the other party will be sent a request for a written response, allowing the other party ten (10) business days to respond.
- The medical policy unit from the Division will facilitate the dispute by reviewing the parties' compliance with Rules 16 and 18 within 30 days of receipt of the complete supporting documentation; or as soon thereafter as possible.
- Upon review of all submitted documentation, disputes resulting from violation of Rules 16 and/or 18, as determined by the Director, may result in a Director's Order that cites the specific violation.

Medical Fee Schedule (Rule 18):

- Establishes the maximum allowable payment but does not limit billing charges
- The Division allows and recognizes provider/payer contracts but does not help enforce them.
- The Division adopts CPT and RBRVS, but always the preceding year. So in 2018, providers/payers would use 2017 RBRVS and in 2019 the Division moves to 2018 RBRVS.
- Utilizes Current Procedural Terminology (CPT) codes, Resource Based Relative Value Scale (RBRVS) and "Z" codes created by the Division of Workers' Compensation

- CMS 1500 is the form required for billing

Cancellation Fees: (Rule 18-6):

- If a patient "no shows" for the appointment, the provider has **two** business days to contact the insurer to reschedule. Upon reporting the missed appointment, the provider may request whether the payer wishes to reschedule the appointment for the claimant. If the claimant fails to keep the payer's rescheduled appointment, the provider may bill for a cancellation fee.
- A cancellation fee is payable only when a payer schedules an appointment the injured worker fails to keep, and the payer has not canceled **three (3)** business days prior to the appointment. (Z0720)

WC -164- Initial Report: (Z0750):

- Must be completed within 14 days of initial visit
- Must be signed by the ATP
- Copy must be provided to the patient

WC-164- Closing Report (Z0752):

- Required from managing provider when patient reaches MMI for all conditions under the workers' compensation claim
- Must state date of MMI, any permanent work restrictions

Special Report (Z0754):

- Routine reports must be submitted free of charge
- Special reports requiring 15 minutes or less can be billed with Z0754. More lengthy reports requiring variable content are billed in 15- minute increments. These codes and requirements are provided in Rule 18-6(G).

Independent Medical Examinations: Three types:

1. Respondent Requested: Must be recorded, recording fee code: Z0766, copy of recording fee: Z0767
2. Claimant Requested:used to challenge a non-DIME impairment rating
3. Division Requested: must be Level II accredited physician to perform when there has been a dispute regarding MMI or impairment rating

All parties receive a copy, no matter which party requests the examination

Technical component of a procedure includes practice expense: equipment, supplies and/or staff and is billed with a TC modifier

- In order to ensure safety, starting January 1, 2017, to bill for the technical component of an MRI, CT scan or nuclear medicine scan, the rendering facility must have obtained accreditation in advance medical imaging.

Professional component of a procedure is for a physician supervising/interpreting a test and is billed with a 26 modifier

Total component: technical and professional component as defined in RBRVS

Evaluation and Management (E&M) Level of Service (Rule 18, Exhibit 7) is determined by: history, examination and medical decision making; or time

- Documentation standards for time:
  - Time can be a factor if at least 50% or more of the visit is face to face disability counseling or coordination of care with documentation of the actual time spent. This excludes any time spent performing any separate billable procedures or diagnostic tests.
  - Must be documented in the record and be patient specific
  - Amount of time and specifics of coordinating care with others (who, what, when and where)

Any separately billable procedure or diagnostic test report must be able to be separately identifiable from any E&M report and the E&M code must have the appropriate modifier appended (-25 or -57)

Documentation for reimbursement should include:

- Shared decision making
- Functional goals and outcomes; and
- The ability for other medical professionals to be able to read through the medical record and have a comprehensive understanding of where the patient is at in the continuum of care.

Manipulation (18-5 (H)(5): does not qualify as an office visit

An E&M visit may be billed on the same day as manipulation codes when the record documents significant services exceeding the usual medical care associated with manipulation.

- Maximum limit: 2 different modalities or 1 hour of procedures per day, per discipline

HIPAA in Workers' Compensation:
Privacy rules permit covered entities to disclose private health information (PHI), without patient authorization to:

- Workers' compensation insurers
- State administrators
- Other entities when the patient has signed a release

Medical records not pertaining to the work injury should **not** be included.
A physicians primary responsibility is to *protect the patient*
Workers' Compensation insurers are NOT covered by HIPAA, YOU ARE THE LAST STOP.
It is highly recommended to obtain a signed medical release from the patient because:

- Insurers could release records to employers
- Independent Medical Examinations could obtain the information because parties receive a copy of the final reports
- Nurse Case Managers may be involved in the patient's case (patients may refuse this service)

Privacy Rules require a patient's authorization prior to a disclosure of psychotherapy notes for **any** reason.

An employer is entitled to work restrictions and time off work information

- Keep information on the WC-164 related to the workers' compensation claim
- Send a copy of the WC-164 to the insurer and the patient
- If you discuss these issues with patient's supervisor, you are required to document this conversation

Discharge for Non-Medical Reasons: Desk Aid 15

- Requires written notice to the injured worker and insurer within 3 business days of a non-medical discharge and notice *must be sent **certified mail**.*
    - For ease, the Division has created a template letter to send certified mail. This can be billed as a form using Z0754
- Explanation of reasoning must be included.
    - Examples of non-medical reasons are you're closing your practice or a patient is uncooperative with staff
        - If closing your practice, offer to transfer the patient's records

If the patient is seeking treatment for a non-work related issue/condition, you can choose whether or not to treat this. If you choose not to, you must send the notification specific to the issue/condition. Be sure to complete the WC-164 form, Section 7
The insurer has 15 days to designate a new physician for the patient.

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Desk Aid 15

Instructions:

Attached are an algorithm and sample letter to assist the physician or physician's office with implementing the new processes established by C.R.S. §8-43-404(10)(a) (2014). This statute sets forth the manner in which a physician must formally notify the patient and insurer when discharging or refusing to treat a workers' compensation patient for *non-medical* reasons. The attached algorithm provides some guidance for applying these procedures under various scenarios.

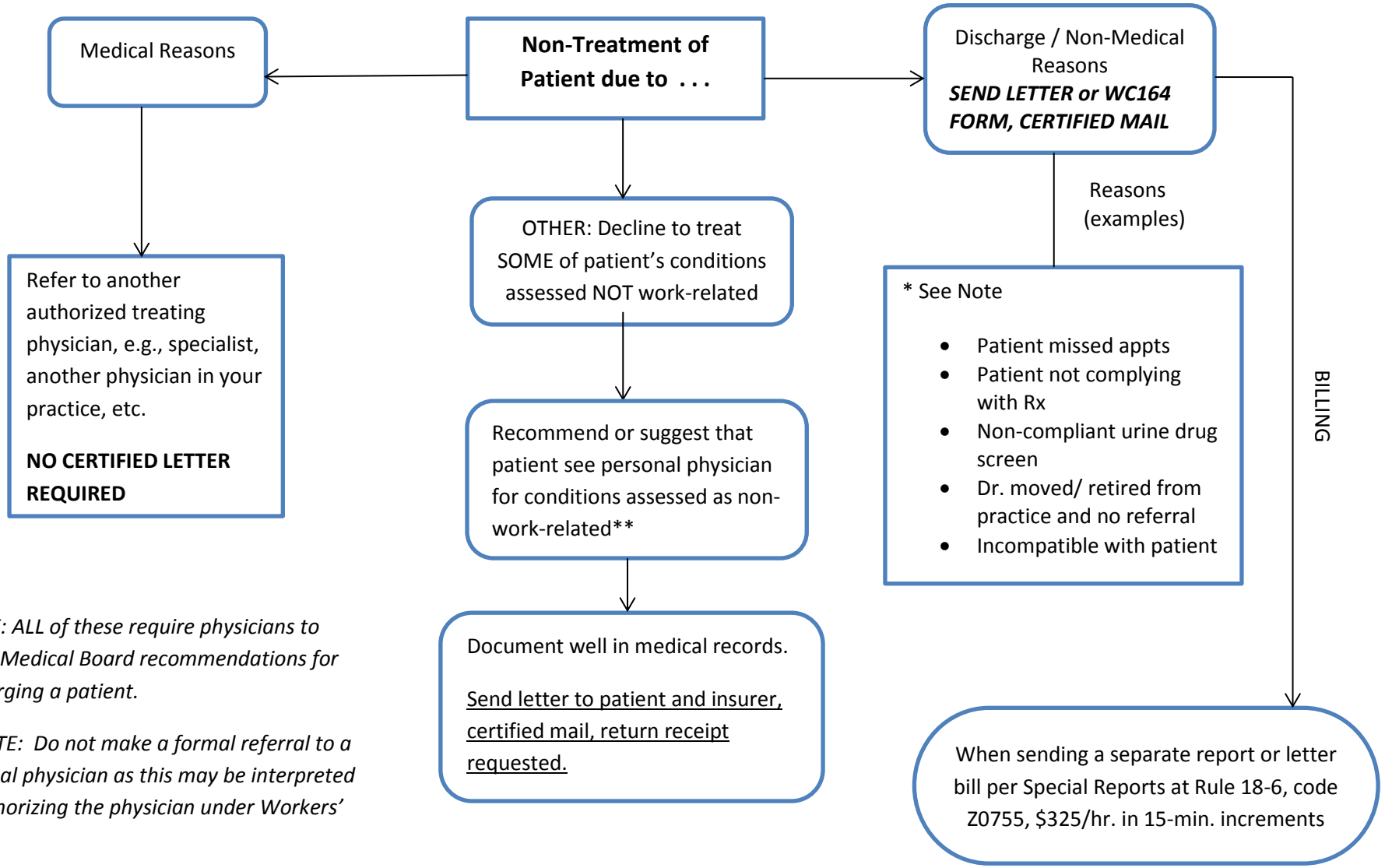
The letter / template may be used by the physician or medical office as the notice under these procedures. It may be modified as needed or a physician's own draft may be used as long as it includes the elements required by the above-referenced statute. For example, the notice must explain the reason for the discharge or refusal to treat, and include an offer to transfer the injured worker's medical records to a new physician upon receipt of an appropriate release.

The letter must be sent to the injured worker and the insurer or self-insured employer on the case via Certified Mail, Return Receipt Requested, within 3 business days of the decision to discharge or refuse to treat.

Informal guidance re: process established in C.R.S. §8-43-404(10)(a)(2014) regarding discharge/refusal to treat based on non-medical reasons

WHEN TO SEND CERTIFIED LETTER OR WC164 FORM TO INSURER AND PATIENT

- Send within 3 business days of decision to not treat
- Send certified mail, return receipt requested



**NOTE: ALL of these require physicians to follow Medical Board recommendations for discharging a patient.*

*** NOTE: Do not make a formal referral to a personal physician as this may be interpreted as authorizing the physician under Workers' Comp.*

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[PHYSICIAN OFFICE LETTERHEAD]

VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED

[Name of Injured Employee/Insurer/Self-Insured Employer]
[Address, Line 1]
[Address, Line 2]

Re: [Name, Claim Number, etc.]

Dear [Injured Employee/Insurer/Self-Insured Employer]:

This is a notification pursuant to §8-43-404(10)(a), C.R.S., that the undersigned authorized physician declines to treat or discharges the injured employee, [Insert Name], from medical care even though [Mr. or Ms. Name] may require continued medical treatment to cure and relieve the effects of the work injury. The reason(s) for this action is/are:

___ Injured employee requests treatment for a condition that is unrelated to the work injury: [insert brief description of the injured employee's complaints]

___ Injured employee missed appointments on: [insert dates of missed appointments]

___ Injured employee has not complied with the treatment: [insert details of non-compliance]

___ Injured employee is non-compliant with a drug/alcohol screen: [insert date and type of drug screen, what drug, etc.]

___ Injured employee has been abusive to the physician, staff or other patients: [insert explanation]

___ Authorized physician has moved or closed the practice; no referral is provided.

___ Other: [insert explanation]

Pursuant to §8-43-404(10)(a), C.R.S., the undersigned authorized physician will transfer the injured employee's medical records to any new authorized physician upon receipt of a signed authorization to do so from the injured employee.

Please contact [insert physician name or another person at physician's office] if you have any questions. Thank you for your attention to this matter.

Sincerely,

[Authorized Physician]

cc: [as needed]

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The "Must Know" Rules Workshop

1. To whom do you owe primary responsibility at all times?
A. The State of Colorado Workers' Compensation System.
B. The patient's employer.
C. The insurance company whose network you belong to.
D. The patient

Reference: ACOEM Code of Ethics

2. An insurer requires a copy of your medical records to justify your billing level. Your office:
A. Copies and sends the complete narrative report
B. Sends the physician's complete narrative report if the patient signed a medical record release form for billing purposes.
C. Notifies the patient in writing that the physician's complete narrative report will be sent to the insurer.

Reference: Colorado Interprofessional Guidelines

3. You are treating a patient for a work-related low back injury. In the course of taking the initial history you note that the patient has been treated for depression multiple times in the last ten years and has a 20-year history of schizophrenia. The patient is currently taking medication for the schizophrenia. The employer requests a copy of physician's initial narrative report, which contains this psychiatric history, in order to determine whether they wish to challenge the work-relatedness of his condition. Your office:

A. Copies and sends the complete narrative report with the physician's initial report.
B. Sends the physician's complete narrative report if the patient signed a medical record release form for billing purposes.
C. Notifies the patient in writing that the physician's complete narrative report will be sent to the employer.
D. Sends the complete narrative report to the employer if the patient has signed a specific release to the employer allowing release of psychological information.

4. You submit a request for prior authorization to incorporate a third modality into a treatment plan and have not received a response from the insurer in 8 business days. You should:

A. File an appeal with the insurer and provide additional medical records.

B. Presume it is authorized and proceed with treatment.

C. Inform the patient so he/she can follow-up with the insurer.

D. Discharge the patient for non-medical reasons.

Reference: Rule 16-10

5. In a workers' compensation claim, an employer is entitled to which of the following records when no medical record release form has been signed by the patient?

A. Complete medical records including history of past medical illnesses that are unrelated to injury.

B. Current information regarding diagnosis, detailed treatment plans and names of consultants.

C. Information in the medical record directly related to the workers' compensation claim.

D. Work restrictions and time off work information.

Reference: ACOEM Code of Ethics, Statutes §8-47-203(1), §8-43-404(4)

6. A patient fails to show for an appointment he scheduled with your office. You should:

A. Bill the patient a $30 no show fee.

B. Discharge the patient for non-medical reasons.

C. Bill the insurance company for half of your usual fee.

D. Contact the insurance company within 2 business days to reschedule the patient.

Reference: Rule 18-6(B)

7. An independent nurse case manager hired by your patient's workers' compensation insurer contacts you by phone. The patient is represented by an attorney. You are asked to discuss the patient's current work status including restrictions, compliance with the current treatment plan, and any abnormal pain behaviors you have observed while examining the patient. You should:

A. Discuss all of the above topics with the nurse case manager because the workers' compensation statute waives any protection.

B. Limit the discussion to work restrictions and place a note in the patient's chart.

C. Talk to the patient before having any discussion with the case manager.

D. Do not discuss any topics with the nurse case manager because you have no release from the patient.

Reference: Statutes §8-42-101(3.6)(p)(I)(A) and §8-42-101(3.6)(p)(II), American Chiropractic Association of Code of Ethics, Colorado Chiropractic Practice Act §12-33-126 C.R.S., Colorado Board of Chiropractic Examiner Rules and Regulations Statute §25-1-802(1)

8. You have spoken with the patient's supervisor about your patient's work restrictions. You are required to:

A. Record the conversation and keep a copy for 12 months.

B. Do nothing – it is only a conversation about work restrictions.

C. Document the conversation, bill the insurer and send a copy of the documentation to the patient.

Note:
Telephonic meeting by a non-treating physician with employer – Z0601 $74/15 minutes or
Telephonic meeting by a treating physician with employer – Z0701 $85/15 minutes
Reference: 18-6(A)

9. You perform an independent medical exam on a workers' compensation patient who requested the exam. You should:

A. Send the report only to the party that hired you.

B. Send the report to the patient, their attorney, and the workers' compensation insurer or employer.

C. Make a full audio-recording of the examination

Reference: Statute §8-43-404(2), Rule 8-8 et seq.

10. A chiropractor can be an Authorized Treating Physician in all cases except:

A. When referred by an Authorized Treating Physician

B. When an injured worker submits the request to the insurer and there is no objection with 20 days.

C. When listed on an employers “Designated Provider List”.

D. When designated by an Administrative Law Judge.

Reference: Statute §8-43-404(5)

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The "Must Know" Rules for Workers' Compensation

ANSWERS

1. D.The patient.

Remember the Hippocratic oath. The workers' compensation statute also gives the authorized treating physician (ATP) significant weight in most situations, presumably because they can best assess the patient's medical condition and treatment needs.

2. B. Send if patient signed release for billing purposes.

Under the HIPAA regulations, no authorization is required to release records for the purposes of obtaining payment. Additionally, HIPAA specifically states that "a covered entity may disclose protected health information as authorized by and to the extent necessary to comply with the law relating to workers' compensation…" (CFR 164.512(l)). In Colorado, Rule 16-7(E)(2) of the rules and regulations of the Division of Workers' Compensation states that the provider shall provide the payer with all supporting documentation including "copies of the examination, surgical, and/or treatment records" when submitting the bill. Therefore, in Colorado a physician can treat an injured worker and provide the required documentation for billing purposes without obtaining a written authorization. However, the best policy is to obtain a signed patient release before sending narrative records to the insurer for billing purposes. The physician will be best protected if the patient has signed a consent, or at a minimum received notice, that a full narrative record will be sent to the insurance company for billing purposes. When obtaining a release, the physician should be sure that any authorization is valid under HIPAA regulations.

As a side note, physicians should be aware that workers' compensation insurers are not covered entities under HIPAA and therefore are not required to abide by the HIPAA statute. This may create potential problems for physicians as some insurers routinely provide the full medical records they receive from the physician to ***employers***. Given the complex interplay between the Colorado workers' compensation and the HIPAA regulations, physicians may be concerned that information in the medical record which is not directly related to the workers' compensation claim, and is sent to the insurer for billing purposes, may then be sent to the employer by the insurer. The Division has issued an interpretive bulletin on this issue. (A copy is attached for your convenience.)

A helpful suggestion would be for a physician to include a cover sheet with records that are submitted for billing purposes. This cover sheet should clearly indicate that the physician has released this protected health information only pursuant to Rule 16, that this information should not be used for purposes other than payment of the claim, and the information should not be re-released to other parties for any other purpose.

3. D. Send only with signed patient release for psychiatric records.

An employer must have a signed release from the patient to obtain these records. (Colorado Interprofessional Guidelines ¶ 3, and generally, Health Administration statute §25-1-802). Psychiatric records require a specific release from the patient. In this case the psychiatric condition is not pertinent to the claim and therefore does not need to be released to the employer. Workers' compensation statute §8-43-404(4), and ACOEM Ethics Principle No. 5.

4. B. Presume it is authorized and proceed with treatment

Under Rule 16-10 (C), the payer should respond within seven business days from receipt of the provider's completed request. If the payer does not respond within seven days, the request is presumed authorized.

5. D. Work restrictions and time off information

Past records can only be supplied if you have a patient release.

6. D. Contact the insurance company within 2 business days to reschedule the patient.

18-6 (B)(2): When claimants fail to keep scheduled appointments, the provider should contact the payer within 2 business days.
Per Rule 18-6(B)(1), a cancellation fee is payable only when a payer schedules an appointment the injured fails to keep, and the payer has not canceled three business days prior to the appointment.

7. D. Do not discuss any topics with the nurse case manager because you have no release from the patient.

A release from the patient is necessary for you to discuss their case with the case manager.

8. C. Document the conversation, bill the insurer and send a copy of the documentation to the patient.

9. B. Send the report to the patient, their attorney, and the workers' compensation insurer or employer. Statute 8-43-404 (2)

10. C. When listed on an employers "designated provider list"
Statute 8-43-404(5) states the employer or insurer shall provide a list of at least 4 physicians or 4 medical providers from which an injured employee may select. The designated provider list does not include chiropractors, although they are considered authorized treating physicians when referred by and ATP, when an injured worker submits the request to the insurer and there is not objection within 20 days or when designated by and administrative law judge.

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Interpretive Bulletin on the Release of Medical Information

Director's interpretations of issues impacting the Colorado workers' compensation system

In an effort to provide guidance on the practical applications of the Colorado Workers' Compensation Act, we will be publishing Director's interpretations of statutes and other factors affecting the system, in the form of Interpretive Bulletins. The purpose is to provide greater levels of consistency and predictability as to how the Colorado system is intended to operate. While the opinions do not have the force and effect of rule, they are afforded as navigational tools to clarify and simplify processes, create efficiencies, and to reduce litigation.

If you have questions regarding this information or issues you would like to see addressed in future bulletins, please direct your inquiries to Paul Tauriello, Director of the Division of Workers' Compensation, at 633 17th St., Suite 400, Denver, CO 80202, FAX 303.318.8632, or e-mail at paul.tauriello@state.co.us

RELEASE OF MEDICAL INFORMATION Release Date: 5/22/02 Revision Date:

This interpretive bulletin addresses issues concerning the privacy of medical information in relation to the required exchange of medical reports in workers' compensation matters. In particular, this bulletin will note the distinction between a medical report and a medical record within the workers' compensation system, and address the issue of what records need to be submitted by a medical provider for payment, versus what records may be released by the insurer.

Privacy of Medical Information

Regulations required by the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") are soon to be implemented, and concerns exist regarding the privacy mandates of this statute and the possible impact on the exchange of medical information within the Colorado workers' compensation system.

The federal Department of Health and Human Services ("HHS") presently requires compliance on April 14, 2003, of the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule"). The Privacy Rule, as it is currently adopted, creates a comprehensive federal system designed to assure the confidentiality of medical records through a regulatory scheme that applies to doctors and other medical professionals, as well as "health plans," all of which are considered "covered entities" under the rule. Covered entities generally must safeguard "protected health information" ("PHI") -- an individual's medical records that include basic health and disability status and health history -- and they may use and disclose PHI only as prescribed by the Privacy Rule.

The Privacy Rule as it currently stands, may be interpreted in a manner which impacts workers' compensation by restricting medical providers and other covered entities from disclosing medical information which may be pertinent to workers' compensation cases. Workers' compensation insurers, self-insured employers, firms that provide services to workers' compensation insurers and self-insurers ("workers' compensation payers"), and workers' compensation adjudicative agencies, are not covered entities under HIPAA and the Privacy Rule. The Privacy Rule allows them to use

and disclose information to downstream entities pursuant to state law and practice. However, they receive information from medical providers who are covered entities. The Privacy Rule states that covered entities can only disclose the "minimum amount of PHI necessary" in response to a request for medical information.

There is an exception under the Privacy Rule, however, that allows covered entities to disclose PHI to the extent necessary to comply with state workers' compensation laws. [1]Therefore, under the Privacy Rule, the release of health information within the workers' compensation system by covered entities should be determined according to state law.

Section 8-47-203(1), C.R.S., provides that filing a claim for workers' compensation is deemed to be a limited waiver of the doctor-patient privilege to persons who are necessary to resolve the case. The limited waiver applies to the injury or disease that is the subject of the case. The medical treatment and resulting medical reports are limited to the work-related injury or disease, and therefore, are subject to the disclosure and exchange requirements mandated by Rule XI (B) [*currently Rule 5-4*], of the Division of Workers' Compensation Rules of Procedure. In addition to the statutory limited waiver, in many instances, the claimant signs a release of medical information at the request of the carrier, or at the medical provider's office at the time of the initial visit. At some point, however, the releases of medical information may become more specific and restrictive than those currently used. Therefore, the statutory limited waiver and the scope of any specific release, define subsequent exchanges of health information within the Colorado workers' compensation system beyond the mandates of the Privacy Rule.

Medical Report vs. Medical Record

Section 8-43-404, C.R.S., and Rule XI [*currently Rule 5*], of the Division's Rules of Procedure, reference the term medical "report." It is helpful to note the distinction between the terms medical report and medical record within the workers' compensation system. A medical report is a medical record, but a medical record is not necessarily a medical report. A medical report is generated either after examination of the claimant, or based on a document review. A medical report in the workers' compensation context refers to information regarding the work-related injury or disease at issue. Medical record is a broader term, and can include information not directly related to the injury or disease at issue.

[1] See, Section 164.512 (l), 45 CFR, Part 164, Standards for Privacy of Individually Identifiable Health Information: Final Rule.

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Release of Medical Records by Provider for Payment

A medical provider must forward the medical information generated from an examination of the claimant to the insurer, third party administrator, or self-insured employer ("payer") in order to be paid. At the time of the initial visit, as well as some follow-up visits, the scope of a medical examination goes beyond the specific injury or disease that is the subject of the workers' compensation case. As a result, protected health information, such as previous medical history or an underlying disability, may be included in the resulting medical records. There are many occasions when this other information is necessary in determining payment to the medical provider. If there is a written release in place, it will allow the exchange of this medical information from the provider to the payer. In the absence of a written release, it is the Director's position that the exchange of medical records under these circumstances is generally covered by the statutory limited waiver and workers' compensation case law.

Release of Medical Records by Payer

In certain instances, medical information received by the payer from the medical provider should not be released to other parties in a workers' compensation case. For example, a payer might receive medical records from the medical provider that contain protected health information **not** related to the workers' compensation injury or disease. In such cases, it may be that this information should not be forwarded to anyone else unless a specific release is obtained. Medical information received by the payer should be evaluated for relevance to the injury or disease. While the employer is entitled to receive medical reports and medical records to the extent necessary to resolve the case, and to be involved in the administration of a case, there may be circumstances when personal medical information not directly related to the injury or disease at issue should not be forwarded to the employer, or anyone else. [2]

[2] When the employer is self-insured, the employer should consult state and federal laws regarding privacy and confidentiality protections in order to safeguard protected health information received from a provider.
Applying these guidelines to a specific situation may be difficult and will depend on the individual facts presented. Under the Colorado workers' compensation system, medical information relied upon in taking a position on a workers' compensation case, other than medical information not related to the workers' compensation injury, should be provided to the other parties. Parties must also remember that any documents to be introduced at hearing, pursuant to Section 8-43-210, C.R.S., must be exchanged prior to hearing, pursuant to Rule VIII of the Division's Rules of Procedure.*
The issue in many instances will be what information is related to the injury or disease in question, and what information is necessary to resolve the workers' compensation case. It is not always clear what records are directly related, and disputes over the release of medical information should be presented to an Administrative Law Judge for resolution. *This is currently under the rules of the Office of Administrative Courts

It is the Director's position that a medical record containing protected health information not related to the injury or disease at issue should not be presumed to be a medical report as contemplated by the statutes and rules. Therefore, the medical records at issue may not be subject to the mandates of Section 8-43-404, C.R.S., and Rule XI *[currently Rule 5]*, of the Division's Rules of Procedure, which require the exchange of medical reports between the parties. The parties to a workers' compensation case should carefully assess at each stage of the case what medical records are being forwarded to other parties, in order to safeguard protected health information.

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HIPAA & Colorado Workers' Compensation

May 2003

The privacy rules implementing the federal Health Insurance Portability and Accountability Act ("HIPAA") took effect April 14, 2003. Although the federal HIPAA privacy rule does not apply to workers' compensation insurers, workers' compensation administrative agencies or employers (unless covered in some other capacity), it does affect these groups. These groups, and others, need access to health information to administer the states' workers' compensation systems and provide the benefits guaranteed to injured workers under those systems. Much of this information must come from health care providers and others who are covered by the federal privacy rule. The complexity of the new privacy rule, and ambiguous language in the rule, both contribute to general confusion regarding its boundaries.

In an attempt to clarify confusion on the basic issues, the following questions and answers regarding the federal HIPAA privacy regulations and Colorado workers' compensation are presented. The answers have been created by the Colorado Division of Workers' Compensation, without approval or endorsement by any federal agency. The DOWC suggests that you consult your own legal counsel regarding these answers or any area of concern that you may have regarding HIPAA and Colorado workers' compensation.

1) Are workers' compensation insurers or self-insurers covered under HIPAA?

No, the definition of 'covered entity' includes health plans, but this definition (found in section 160.103 of the Privacy Rule) excludes any plan that provides the excepted benefits listed in the Public Health Service Act, section 2791(c)(1). The excepted benefits include workers' compensation ("WC"). Of course, WC insurers or self-insurers could be engaged in other business that would make them covered entities.

2) Can health care providers (who are covered entities under HIPAA) disclose information to non-covered entities?

Yes. From the Preamble to the Privacy Rule, "even though workers' compensation insurers are not covered entities under HIPAA, providers who are covered entities may disclose protected health information to them for payment purposes", assuming the providers have listed such insurers on their Notice of Privacy Practices. (Federal Register, December 28, 2000, page 82495)

3) Does this relationship between health care providers and workers' compensation payers create a "business associate" relationship?

No. The term "business associate" basically refers to a vendor or contractor. It is not meant to refer to a WC insurer. "The business associate relationship does not describe all relationships between covered entities and other persons or organizations….For example, when a health care provider discloses protected health information to health plans for payment purposes, no business associate relationship is established." (Federal Register, December 28, 2000, page 82476) This is important, because it obviates the requirement for a business associate contract between providers and WC payers.

4) Can health care providers disclose protected health information for workers' compensation purposes?

Yes. Section 164.512 (l) of the Privacy Rule specifically allows covered entities to disclose protected health information ("PHI") "as authorized by and to the extent necessary to comply with" state workers' compensation law or regulations. A possible exception to this is with regard to psychotherapy notes, which require a specific authorization under HIPAA (164.508 (a) (2)).

5) What does "authorized by law" mean?

According to the recently released "HIPAA Privacy Rule and Public Health Guidance from CDC and the U.S. Department of Health and Human Services": "Although it is not a defined term, DHHS interpreted the phrase "authorized by law" to mean that a legal basis exists for the activity. Further, DHHS called the phrase "a term of art," including both actions that are permitted and actions that are required by law [64 FR 59929, November 3, 1999]. This does not mean a public health authority at the federal, tribal, state, or local level must have multiple disease or condition specific laws that authorize each collection of information. Public health authorities operate under broad mandates to protect the health of their constituent populations."

This definition is relevant to WC, because 164.512 (l) allows health providers to use and disclose PHI "as authorized by and to the extent necessary to comply with" state WC laws. Workers' compensation traditionally has relied on claimant medical information to resolve a WC case. This information is still required under HIPAA. In Colorado, the filing of a WC claim is deemed to be a limited waiver, although as a practical matter, obtaining a release is a useful practice.

6) What does Colorado workers' compensation law say about releasing medical information?

See sections 8-43-404 (2) & (4), and 8-47-203 (1); also Rules 5-4(A)(5); 16- 7(E)(4); 18-6(G). Additionally, the Director of the Division of Workers' Compensation has issued an Interpretive Bulletin regarding Release of Medical Information. All of these may be found on the DOWC web site at www.coworkforce.com/DWC.

These are summarized in part below:

8-47-203 (1) "…the filing of a claim for compensation is deemed to be a limited waiver of the doctor-patient privilege to persons who are necessary to resolve the claim."

8-43-404 (2)" Both employer and employee are entitled to medical reports regarding treatment of the work-related injury. "

8-43-404 (4) "A physician…will not be required to disclose confidential communications imparted…for the purpose of treatment and which are unnecessary to a proper understanding of the case."

DOWC Rule 5-4(A)(5) "A copy of every medical report not filed with the Division shall be exchanged with all parties within fifteen working days of receipt."

DOWC Rule 16-7(E)(4) "Providers…shall provide the payer with all supporting documentation at the time of submission of the bill…This shall include copies of the examination, surgical, and/or treatment records."

DOWC Rule 18-6(G)(1) "Completion of routine reports or records are incorporated in all fees for service and include...Diagnostic Testing, Procedure Reports, Progress notes, Office notes, Operative reports" DOWC Rule 18-6(G)(2) Form WC164 medical reports are required for initial and closing appointments. WC164 reports may be requested for progress reporting.

Interpretive Bulletin #9: Release of Medical Records. This bulletin discusses the distinction between "medical report" and "medical record". A record may include PHI that is not directly related to the WC claim, but is necessary to justify the payment charged. A report should only discuss medical issues regarding the WC injury. The WC payer has the right to receive all the information necessary to determine payment for appropriate medical services. The employer has the right to reports regarding the WC injuries, but not a clear right to records containing irrelevant PHI. Given that privacy laws are in the limelight and are changing, the payer and employer should be cautious when sharing PHI.

7) What is necessary for the release of medical information?

It depends on the purpose for which the release is needed. For example, HIPAA only requires patients be given a "Notice of Privacy Practices" to release PHI for payment, treatment or health care operations. Other releases may be made pursuant to state workers' compensation law (e.g., WC164 Forms, IME reports). Finally, some releases will probably require an Authorization, such as releases of medical records by non-WC physicians for medical treatment prior to the WC injury.

8) Is it necessary to have an authorization signed by the injured workers to release medical information for payment purposes in workers' compensation?

Not usually. HIPAA requires health care providers to give patients a "Notice of Privacy Practices". This document should include workers' compensation as a possible recipient of medical information. Health care providers are allowed to engage in a broad range of treatment, payment and healthcare operations activities without a written consent so long as the required Notice has been given to the patient. (164.506 (c)(1))

Current Colorado workers' compensation law has not required a release for payment purposes. Colorado law has been crafted in an environment where health care providers were obtaining signed releases prior to any payment activities. Under HIPAA, the Notice will replace this release, and there is nothing specific in Colorado WC law to require an additional release for payment purposes.

The only apparent exception to this general assessment of release of PHI for payment is that HIPAA requires an explicit authorization to release psychotherapy notes. For payment purposes, HIPAA apparently allows release without authorization of defined summary statements regarding mental health treatment. (164.508 (a) (2) and definition of 'psychotherapy notes' in 164.501)

9) What falls under "payment"?

The HIPAA definition of "payment" includes (but is not limited to) such activities as billing, determinations of eligibility or coverage, and review of health care services with respect to medical necessity, appropriateness of care, or justification of charges (164.501). Payment activities also include those necessary for preauthorization of services.

10) Do "payment activities" cover the release of medical information to an employer who is not acting as its own claims administrator?

No. According to the Preamble, HIPAA does"… not interpret the definition of 'payment' to include activities that involve the disclosure of protected health information by a covered entity…to a plan sponsor for the purpose of obtaining payment under a group health plan maintained by such plan sponsor, or for the purpose of obtaining payment from a health insurance issuer or HMO with respect

to a group health plan maintained by such plan sponsor, unless the plan sponsor is performing plan administration pursuant to 164.504 (f).” (Federal Register, December 28, 2000, page 82495) Although this statement does not refer to workers’ compensation benefit plans, it suggests the intent of HIPAA with regard to information being provided to employers under the definition of ‘payment’. Thus, for release of WC case information to non-self-administered employers for workers’ compensation purposes it is best to rely on 164.512 (l), and on Colorado workers’ compensation law.

11) Can a provider send work restrictions to an employer without a specific authorization from the patient?

Under HIPAA’s Privacy Rule section 164.512 (l), health care providers may disclose information as authorized by state workers’ compensation law. Under Colorado’s Workers’ Compensation Act at 8-47-203 (1), the filing of a claim for compensation is a ‘limited waiver of the doctor-patient privilege to persons who are necessary to resolve the claim’ and at 8-43-404 (2), the employer is entitled to any reports related to the injury given to the injured worker by either an employer- or employee selected physician or chiropractor. Further, the Division of Workers' Compensation’s (DOWC) “Physician’s Report of Workers’ Compensation Injury” (Form WC164) includes information regarding work restrictions. The WC164 form is required documentation by DOWC Rule 16-7(E). for the initial and final physician visits, and may be requested by the payer for intervening visits.

Given these facts, it is the Division’s assessment that state workers’ compensation law authorizes reporting work restrictions to the employer of a workers’ compensation claimant. This should be accompanied by providing the same information to the claimant, of course.

12) What about an insurer sending work restrictions to an employer without a specific authorization from the patient?

As noted in response to question 1, a workers’ compensation insurer is not a covered entity under HIPAA. Non-covered entities are not subject to any of HIPAA’s requirements. Therefore, once medical information has been properly disclosed to a non-covered entity, HIPAA is not applicable.

13) Does a provider have to account for disclosures made for workers’ compensation, even when Colorado law requires them?

Yes, disclosures made as permitted or required by workers’ compensation law must be included if the patient requests an accounting of disclosures under HIPAA. However, disclosures made for treatment, payment, or health care operations do not have to be accounted for, whether they were made for workers’ compensation or for covered entity health plans. Similarly, any disclosures made with the authorization of the patient, if made according to that authorization; do not have to be included in the accounting record. (164.528 (a)(1))

14) HIPAA allows patients the right to request restrictions on confidential communications. Will this keep a provider from being able to send the PHI to workers' compensation entities?

No, HIPAA recognizes that this request is not allowed for 164.512 uses and disclosures (see 164.522 (a)(1)(v)). Workers' compensation would fall under the 164.512 exemptions, and therefore, there is no apparent conflict between Colorado WC and HIPAA on this point.

15) HIPAA gives patients the right to request an amendment of their medical records. Is there any law regarding amending records in workers' compensation?

There is nothing in Colorado workers' compensation law about amending a record. For many WC cases, the WC payer may already have the original record, and may question any changes. If not, however, amending the record may impact the WC outcome in ways that the provider could not predict. For this reason, the Division strongly urges providers not to amend their records when WC cases are involved. Instead, link the suggested amendments to the original record as allowed by HIPAA.

16) Is the Division of Workers' Compensation a covered entity or a business associate?

No. The DOWC does not qualify as a health care provider, a health plan, or a health care clearinghouse. Additionally, the DOWC does not act 'on behalf of' any covered entities in providing those functions that make them covered entities.

Further, the DOWC is a "health oversight agency", which exempts our laws and rules from HIPAA mandates, under the protection found in sections 160.203 (c) or (d). It follows that a covered entity may release all information requested by the DOWC without concern for 'minimum necessary'. (see 164.514 (d)(3)(iii)(A))

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17) Do health care providers have to use a HIPAA-compliant authorization for WC cases?

When a health care provider who uses electronic transactions, and is thus subject to HIPAA is required to get an authorization, it must be HIPAA compliant to be valid under federal law. Nothing in Colorado's WC law defines the elements of a valid authorization, so while state WC law may impact the decision regarding whether an authorization is required for a specific release, it does not change the necessity for a covered entity to rely on a valid authorization.

There are a number of common disclosures in WC that do not require an authorization, for example:

For Payment, Treatment, or Health Care Operations: See prior FAQ.

For work restrictions report to employers: See prior FAQ.

Other web sites you may find helpful on this topic are:

- U.S. Dept. of Health & Human Services http://aspe.os.dhhs.gov/admnsimp
- Office of Civil Rights http://www.hhs.gov/ocr/hipaa/privacy.html
- Workgroup for Electronic Data Interchange www.wedi.org
- Colorado Strategic National Implementation Process www.cosnip.com
- Accredited Standards Committee X2 www.x12.org

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HIPAA Privacy Authorization Form

https://www.athenaeum.edu/pdf/free-hipaa-release-form.pdf

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. □ _____ to _____.

OR

b. □ all past, present, and future periods.

3. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records

□ Communicable diseases (including HIV and AIDS)

□ Alcohol/drug abuse treatment

□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of patient or personal representative

_____

Printed name of patient or personal representative and his or her relationship to patient

_____

Date

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Introduction to the Medical Treatment Guidelines

Objectives

1. Describe the process for guideline development including the process for determining guideline recommendations
2. Identify key components and how they should be used in decision making
3. Identify the General Guideline Principles and discuss how these should be applied
4. Demonstrate application of the guidelines

Guideline Development

- Total of nine medical treatment guidelines (Rule 17)
    - Low back Pain (Exhibit 1)
    - Traumatic Brain Injury (Exhibit 2)
    - Thoracic Outlet Syndrome (Exhibit 3)
    - Shoulder Injury (Exhibit 4)
    - Cumulative Trauma Conditions (Exhibit 5)
    - Lower Extremity (Exhibit 6)
    - Complex Regional Pain Syndrome (Exhibit 7)
    - Cervical Spine Injury (Exhibit 8)
    - Chronic Pain Disorder (Exhibit 9)
        - Includes recommendations for medications
- Each guideline is updated every 5 years
- Guideline Revision Process
    1. A draft of the guideline is created after a literature review by Division staff.
        - Only high level studies are used to create evidence based recommendations.
        - Systematic reviews and randomized controlled trials are the only types of studies used for evidence.
        - A lot of the literature gets eliminated because it does not meet our standards.
        - *Example*: For revision of the chronic pain guideline 1351 articles were reviewed, but only 154 met our quality criteria and were used for evidence.

    2. After the draft is created, Division staff meets with a diverse team (task force) of subject matter experts that includes attorneys, physicians, case managers, etc. to review and revise the draft. This includes development of consensus statements for recommendations where evidence is lacking.

    3. The final draft is then sent to a broader community of industry experts (Advisory Panel) who provide feedback.

    4.Changes and feedback are integrated into the final draft, then it is made available to the public for additional feedback.

    5. The final draft is presented at a public hearing where testimony is heard and then changes are incorporated as needed, the final draft is then adopted into rule.

6. The adopted guideline is submitted to the National Guideline Clearinghouse for publication.

- This whole process takes approximately 12 months from start to finish.

Guideline Recommendations

- All recommendations are based on available evidence or consensus statements.
- Evidence statements are used whenever possible.
    - The strength of the evidence is determined by the number and quality of relevant scientific studies
        - "Strong Evidence" = multiple relevant, high-quality, scientific studies with similar results
        - "Good Evidence" = one relevant, high-quality study or multiple adequate scientific studies
        - "Some Evidence" = at least on adequate study
    - Studies are evaluated and graded by division staff. In order to determine the quality of the study, their assessment of the literature includes:
        - Is the Method of randomization described?
        - Is concealment of allocation described?
        - Did they use blinding or masking when reasonable?
        - Were co-interventions the same?
        - Is the follow-up complete? And are withdrawals accounted for?
        - Is the intention to treat analysis reported?
        - Is there selective outcome reporting?
    - Here is an example of strong evidence from the lower extremity guideline: There is strong evidence that land-based supervised exercise program shows small, but clinically important benefits for the relief of pain and improvement in function. These benefits are sustained for at least another three to six months among people with symptomatic osteoarthritis of the hip. ([Cochrane] Fransen, 2014)

      (Lower Extremity MTG: E. Specific Lower Extremity Injury Diagnosis, Testing, And Treatment, 3. Hip and Leg, b. Aggravated Osteoarthritis: Non-operative Treatment Procedures)

- Consensus Statements:
    - Are developed by using the judgment of experienced professionals based on general medical principles which take into consideration:
        - The functional benefit to the patient, keeping in mind that pain relief alone is not an adequate measure
        - The acceptable risk and morbidity
        - The length of disability and timeframe to recovery
        - The acceptable cost for interventions which have similar outcomes
    - Are used when adequate evidence is not available in the published literature, or when published evidence is conflicting.

    - Typically begin by stating: “It is well-established that…”
- Procedures designated as “not recommended”:
    - Are considered inappropriate, unreasonable or unnecessary
- Prior authorization is not required for procedures that are recommended in the guidelines, although it is important to document functional progress.

Navigating the Guidelines

- All of the guidelines and associated documents can be found on our website: https://www.colorado.gov/pacific/cdle/node/20291
    - Referenced version of the guideline, which is recommended for use, includes a bibliography and references for all of the articles used to create evidence statements.
    - “Assessment criteria” includes the methodology used to include or exclude articles based on the quality of the study
    - “Critiques” are the review of the literature conducted by Division staff
    - “Evidence tables” provide a layout of all of the evidence statements included in the guideline
- Each guideline includes a “Table of Contents”
    - These are organized to reflect a continuum of care
        - Starting with initial diagnostic procedures, then follow up diagnostic imaging, treatment, non-operative and operative therapeutic procedures, all the way to maintenance treatment in some guidelines.
- Each guideline also contains “General Guideline Principles”
    - These are the same throughout all of the guidelines
    - They include:
        1. Application of the Guidelines
        2. Education
        3. Informed Decision Making
        4. Treatment Parameter Duration
        5. Active Interventions
        6. Active Therapeutic Exercise Program
        7. Positive Patient Response
        8. Re-evaluate Treatment Every 3-4 weeks
        9. Surgical Interventions
        10. Six-Month Time Frame
        11. Return to Work
        12. Delayed Recovery
        13. Guidelines Recommendations and Inclusion of Medical Evidence
        14. Care Beyond Maximum Medical Improvement (MMI)
    - They are intended to be used to guide all clinical decision making including:
        - Comparing different types of interventions
        - Justifying treatment beyond a recommended time frame

        - Determining appropriate time frames if no recommendations are outlined
        - Example:
            - *Guideline Principle #9. 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. Clinical findings, clinical course, and diagnostic tests must be consistent in order to justify operative interventions. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions.*
            - This principle demonstrates that it is not recommended to refer a patient for surgery just to relieve pain.
            - It would be important to outline the expected functional outcome as well as ensure that there were pathological findings present in order to justify surgery.
    - Other key components of the General Guideline Principles:
        - Passive interventions should only be used to facilitate progress with active interventions. (General Guideline Principle 5)
        - Conservative treatments should be used prior to invasive procedures
        - Document specific goals that are both functional and measurable.
            - Include objective progress toward goals in your documentation
        - Re-evaluate the treatment plan within the "time to produce effect" outlined in the guidelines or no less than every three to four weeks.
        - Patient education should always be performed by all providers as part of the treatment plan (General Guideline Principle 2)
        - Psychological evaluation should be ordered for cases who have not made expected progress by 6-12 weeks after an injury. (General Guideline Principle 12)
        - Any treatment plan should be assessed every 3-4 weeks for functional, objective gains. (General Guideline Principle 8)
- Most treatment sections include time frame recommendations:
    - Time to produce effect - the time frame in which the intervention should show improvement in the condition
    - Frequency - How often the intervention should be occuring.
    - Optimum Duration - the optimal time frame to increase function and show improvement
    - Maximum Duration - the maximum amount of time the treatment should occur
- When documenting it may be helpful to reference sections within the guidelines
    - Be aware that page numbers may vary between the referenced and non-referenced versions of the guidelines.

Case Examples:

- A patient presents with a grade 2 ankle sprain and the plan is to prescribe therapeutic exercise.
- Refer to the Lower Extremity Guideline
    - 1. Look up the "diagnosis" -
        - Section E. Specific Lower Extremity Injury Diagnosis, Testing and Treatment

          1. Foot and Ankle

                d. Ankle sprain/ Fracture
    - 2. Look at "non-operative treatment procedures" under ankle sprain
        - The guideline states in this section that "early functional treatment (e.g., range of motion, strengthening exercises) with limited weight-bearing..for improving outcome and reducing time to return to work." can be used.
        - And also to "encourage patient to begin mobilization and exercise during the first week after the injury with instruction from a PT or physician."
        - *Essentially, this tells us that the guideline recommends exercise for ankle sprains.*
    - 3. In the table of contents look at "Therapeutic Procedures-Non-operative" and look under "Active Therapy" since the plan is therapeutic exercise.
        - There are time frames listed:
            - Time to Produce Effect: 2 to 6 treatments.
            - Frequency: 3 to 5 times per week.
            - Optimum Duration: 4 to 8 weeks.
            - Maximum Duration: 8 weeks.
        - Maximum number of treatments is maximum frequency of 5 times/ week for maximum duration of 8 weeks, or 40 treatments total.
        - It is important to consider the time to produce effect of 2-6 treatments
            - The provider should be seeing and documenting functional gains by 6 treatments.
                - Patient has improved, they are now able to walk around the block without pain. Plan is to continue with therapy.
        - 40 treatments is most likely too many for a grade 2 ankle sprain
        - If functional gains are not being made by the "time to produce effect", it may be important to consider other options.
        - If you refer to the General Guideline Principles they state "If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued."
        - This demonstrates how to use the time frames listed in conjunction with the General Guideline Principles.
        - On the other hand, if the patient continues to demonstrate functional gains up to the maximum of 40 visits and the provider feels the patient will

benefit from continued therapy, this does not necessarily mean the treatment will be denied.
        - It would be important to justify why the patient would benefit from further treatment. The General Guideline Principles may be helpful in providing this justification.
    - When requesting further treatment within or outside of the listed timeframes it is important to consider the following:
        - Did the current treatment lead to functional gains?
        - If not, was the treatment plan re-evaluated? And did that lead to a modified plan?
        - Was the diagnosis reconsidered? Or should it be?
        - Or perhaps there is a good reason for a delayed recovery?
- Most invasive procedures in the guideline have specific requirements that must be met.
    - An example is Sacroiliac joint diagnostic injections. The low back guideline outlines the following indications in order to consider this treatment:
        - Less invasive procedures must be considered first
        - Must have a strong suspicion for pathologic conditions
        - MRI or CT scan, with compatible findings
        - Source of pain symptoms
        - At least 3 positive physical exam maneuvers.
    - The physical exam maneuvers must be measured pre and post injection and demonstrate a positive patient response.
    - Positive patient response is also outlined in the General Guideline Principles.
    - If there is a positive patient response to the diagnostic injection, and functional gains are demonstrated and documented, then repeat therapeutic injections can be considered.
        - The injections can be repeated 2-3 times per year if they result in increased documented functional benefit for at least 3 months and at least 80% initial improvement in pain scales.
    - These specific indications help to avoid unnecessary treatment.

<u>Take Home Message</u>

- The guidelines and the General Guideline Principles should be used to focus on function by:
    - Doing conservative and active interventions first
    - Following indications and documenting why the patient is appropriate for treatment
    - Documenting functional gains from the “time to produce effect” onwards
    - Documenting that the plan has been modified or stopped if expected progress is not met
    - Providing an explanation for delayed recovery
    - Reconsidering the diagnosis if no functional gains are being made.

- These are all important aspects of treatment to consider because we know that “50% of workers out for 6 months or more will never return to work”

Contact Information for Questions or Comments

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MTG Website: https://www.colorado.gov/pacific/cdle/ medical-treatment-guidelines

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Medical Treatment Guidelines: General Guideline Principles

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 Workers' 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: 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 implement strategies 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 and evidence-based information to the patient. More in-depth patient education is currently a component of treatment regimens which employ functional, restorative, preventive, and rehabilitative programs. 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. INFORMED DECISION MAKING: Providers should implement informed decision making as a crucial element of a successful treatment plan. Patients, with the assistance of their health care practitioner, should identify their personal and professional functional goals of treatment at the first visit. Progress towards the individual's identified functional goals should be addressed by all members of the health care team at subsequent visits and throughout the established treatment plan. Nurse case managers, physical therapists, and other members of the health care team play an integral role in informed decision making and achievement of functional goals. Patient education and informed decision making should facilitate self-management of symptoms and prevention of further injury.

4. TREATMENT PARAMETER DURATION: Time frames 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 time frames discussed in this document.

5. ACTIVE INTERVENTIONS: Emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, is generally emphasized over passive modalities, especially as treatment progresses. Generally, passive interventions facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

6. ACTIVE THERAPEUTIC EXERCISE PROGRAM: Goals should incorporate patient strength, endurance, flexibility, coordination, and education. This includes functional application in vocational or community settings.

7. POSITIVE PATIENT RESPONSE: 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 (ADL), cognition, psychological behavior, and quantifiable efficiency/velocity measures. 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.

8. RE-EVALUATE TREATMENT EVERY 3 TO 4 WEEKS: If a given treatment or modality is not producing positive results within three to four weeks, the treatment should be either modified or discontinued. Before discontinuing the treatment, the provider should have a detailed discussion with the patient to determine the reason for failure to produce positive results. Reconsideration of diagnosis should also occur in the event of a poor response to a seemingly rational intervention.

9. SURGICAL INTERVENTIONS: Surgical interventions 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 condition(s).

10. 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 time frame, whenever possible. It is important to note that time frames may not be pertinent to injuries that do not involve work-time loss or are not occupationally related.

11. RETURN-TO-WORK: A 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 physical limitations and the patient should never be released to non-specific and vague descriptions such as “sedentary” or “light duty.” The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, 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, from including, but not limited to, an occupational health nurse, occupational therapist, vocational rehabilitation specialist, an industrial hygienist, or another professional.

12. 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 timelines discussed within this document, but such treatment requires clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

13. GUIDELINES RECOMMENDATIONS AND INCLUSION OF MEDICAL EVIDENCE: All recommendations are based on available evidence and/or consensus judgment. When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. It is generally recognized that early reports of a positive treatment effect are frequently weakened or overturned by subsequent research. When interpreting medical evidence statements in the guideline, the following apply:

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

- “Some evidence” means the recommendation considered at least one adequate scientific study, which reported that a treatment was effective. The Division recognizes that further research is likely to have an impact on the strength of the medical evidence.

- "Good evidence" 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. The Division recognizes that further research may have an impact on the strength of the medical evidence.

- "Strong evidence" 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. The Division recognizes that further research is unlikely to have an important impact on the strength of the medical evidence

All recommendations in the guideline are considered to represent reasonable care in appropriately selected cases, irrespective of the level of evidence or consensus statement attached to them. Those procedures considered inappropriate, unreasonable, or unnecessary are designated in the guideline as "not recommended."

14. CARE BEYOND MAXIMUM MEDICAL IMPROVEMENT (MMI): MMI should be declared when a patient's condition has plateaued to the point where the authorized treating physician no longer believes further medical intervention is likely to result in improved function. However, some patients may require treatment after MMI has been declared in order to maintain their functional state. The recommendations in this guideline are for pre-MMI care and are not intended to limit post-MMI treatment.

The remainder of this document should be interpreted within the parameters of these guidelines principles that may lead to more optimal medical and functional outcomes for injured workers.

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Level I Accreditation

Cervical Spine/Chronic Pain Medical Treatment Guideline Workshop

Objectives:

1. Identify the treatment protocol for a patient involved in chronic opioid use.
2. Utilize the medical treatment guidelines to determine steps of conservative and operative treatment for the cervical spine.
3. Implement the medical treatment guidelines when discussing treatment options with patients and insurance adjusters.

Instructions: Read the case below and answer the questions by **citing the recommendations in the Chronic Pain or Cervical Spine Medical Treatment Guidelines**, providing relevant titles and sections. Example: Cervical Spine, Section F. (Therapeutic Procedures Non-Operative), Subsection 1 – Acupuncture.

Mr. Crash is a 50 year old male, construction worker who was in a work related car accident on September 1st, 2015. Mr. Crash was driving to a work site with the company vehicle and was rear-ended while sitting at a stop light. The driver at fault was apparently distracted and didn't brake until the last minute. It was estimated, based on the damage to the vehicles, that Mr. Crash's car was impacted at 40 mph. His vehicle was forced into the intersection but fortunately was not hit again by oncoming traffic. He did not lose consciousness, but his head snapped forward and backward forcefully. He was taken to the emergency department where a CT scan was performed. The results of the CT were negative for cervical fractures, but a possible disc bulge at C5-6 with degenerative disc disease was identified and additional facet joint arthrosis at C3-6. He was given opioids, NSAIDS, physical therapy, massage therapy and ice for treatment. At 10 weeks after his injury, Mr. Crash had plateaued with the care prescribed.

You are evaluating Mr. Crash for the first time, because he has been treated by a colleague for the past 12 weeks, and your colleague has moved out of state. Mr. Crash has not returned to work due to cervical pain, which he rates 5/10 and 8/10 with activity. He reports he had tingling in the arm after the accident and it has recently developed into weakness in the right arm and hand, and occasional tingling and aching in the right forearm, thumb and index finger. His physical examination reveals the following:

Sensation: intact bilaterally for light touch, pin prick and 2 point discrimination
Reflexes: 2+ right triceps, 1+ right biceps, 2+ left biceps and triceps
Strength: 5/5 all upper and lower extremity muscles
Cervical range of motion: limited in all planes, with extension and lateral flexion increasing pain.
Pain is also increased with any activity, especially if he tries to lift any amount of weight or reach overhead. Mr. Crash has not been able to decrease the pain medication of 20 mg of oxymorphone 3x/day. You determined this is equal to 180 morphine equivalents per day.

Mr. Crash has many concerns following his injury. He has worked in construction since he was 18 and does not know what else he will do. He admits to frustration and increased anger due not returning to work and states he is not sleeping well. His wife tells him that he is irritable and difficult to live with. He reports he does not feel like socializing with co-workers or family as before. His wife had to return to working full time as they cannot pay the monthly bills with the benefits he is receiving from being off of work.

As the authorized treating physician, you feel Mr. Crash is falling into a delayed recovery category with some signs of depression and his opioid use has continued at a high level. You feel a psychological evaluation may be warranted.

Q1. Mr. Crash wonders why you want to send him to a psychiatrist. What would you say? Cite from the chronic pain medical treatment guidelines for justification of the referral.

The psychological evaluation is approved and Mr. Crash has begun treatment with a psychologist due to the evaluation of depression. Mr. Crash is not able to decrease the opioid use due to pain and he feels the opioids help with the depression he is feeling. He asks for an additional opioid re-fill.

Q2. Apparently, the physician did not follow the recommendations for prescribing opioids. According to the chronic pain medical treatment guidelines, what are the required steps for prescribing the use of opioids?

Q3. According to the Chronic Pain Guidelines, what dosages of opioids are associated with a higher death rate?

The proper steps were taken with Mr. Crash by providing the patient psychological treatment and management of the opioids. Overall, the treatments were successful with him reporting a decrease in anger and frustration, and increased motivation to return to work. He reports his head is "on right" and he wants to do anything possible to return to work. His pain is being managed by minimal opioid use and more with NSAIDS and continued physical and massage therapy. Mr. Crash is reporting increased weakness and pain in his right arm.

The injury occurred 12 weeks ago and his physical examination reveals:

Sensation: intact bilaterally for 2 point discrimination
Reflexes: 2+ right triceps, 1+ right biceps, 2+ left biceps and triceps
Strength: 5/5 all upper and lower extremity muscles

An MRI is obtained due to the neurological symptoms Mr. Crash reports, which seem to be increasing. The results show nerve root compression due to a disc herniation at C5-6 with degenerative disc disease C3-6 and facet joint arthrosis. Mr. Crash wants an EMG test because he is concerned he will never be able to return to construction again. Mr. Crash has also heard of steroid injections and wonders about the effects of these.

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Q4. What conversation would you have with the patient regarding the EMG and if it is necessary? Justify your answer by citing from the cervical spine guidelines.

Q5. You decide to order an EMG for Mr. Crash. Since this treatment is accepted in the guideline, complete the attached Division Notification form for the insurer.

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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation

NOTIFICATION BY AN AUTHORIZED TREATING PROVIDER

NOTIFICATION IS FOR TREATMENT CONSISTENT WITH THE MEDICAL TREATMENT GUIDELINES

Please fill out all required information, as missing information may delay your request

Date of Injury | **Patient's DOB** | **Carrier Claim #** | **Date Sent**

Patient's Name: Last | First | M.I.

Insurance Carrer's/Agent's Name

Address: Number and Street | City | State | Zip Code

AUTHORIZED TREATING PROVIDER SUBMITTING NOTIFICATION

Provider's Name | Phone # | Fax # OR Email | NPI/FEIN

Address: Number and Street | City | State | Zip Code

CERTIFICATION THE PRESCRIBED TREATMENT IS WITHIN THE MEDICAL TREATMENT GUIDELINES

Specify treatment/service(s) and billing code(s) | Dx/ICD-10 Code

Identification of the specific Medical Treatment Guideline applicable to the prescribed treatment/service (Rule 17):

Guideline | Section

☐ Supporting documentation attached

I certify that the prescribed treatment is medically necessary and within the Medical Treatment Guidelines.

ATP's Signature | Date

TO BE COMPLETED BY THE CARRIER. Per Rule 16-9, the self-insured employer or employer's insurance carrier shall respond with their required information (noted in the gray shaded areas) within five (5) business days from receipt of the provider's notification.

- ☐ Form is incomplete
- ☐ Notification Confirmed; Authorization #_____
- ☐ Approval limited in accordance with MTG as follows:_____
- ☐ Notification Denied for the following reason(s):
  - ☐ No admission of liability or final order finding the injury compensable has been issued (for reported claims).
  - ☐ Proposed treatment is not related to the admitted injury.
  - ☐ Provider submitting Notification is not an ATP or is proposing for treatment to be performed by a non-eligible ATP.
  - ☐ Injured worker is not entitled to proposed treatment pursuant to statute or settlement.
  - ☐ Medical records contain conflicting opinions among the ATPs regarding proposed treatment.
  - ☐ The prescribed treatment falls outside of the Medical Treatment Guidelines and will be reviewed as a Prior Authorization. (additional information requested)

I certify that copies of the confirmation/denial were completed and sent to the health care provider on the date below:

By (Print Name) | Signature | Title | Date

Q6. What conversation would you have with Mr. Crash regarding the steps to take for an injection, and the effects and indications of epidural steroid injections? Cite from the cervical spine medical treatment guidelines to justify your answer.

Mr. Crash is frustrated by the chronic pain and decided to try a diagnostic steroid injection which improved his arm pain by 50%, however; the most limiting aspect is neck pain and he wants that resolved.

Physical Examination:

Sensation: intact bilaterally for 2 point discrimination
Reflexes: 2+ right triceps, 1+ right biceps, 2+ left biceps and triceps
Strength: 5/5 all upper and lower extremity muscles

Q7. Mr. Crash feels he wants a long term fix and would like to have a cervical fusion like Payton Manning since his surgery was successful. According to the cervical spine guidelines, would a fusion be approved by the insurer? Cite the guidelines to justify your answer.

Q8. Would a total cervical disc replacement be an option for Mr. Crash? Justify your answer from the treatment guidelines.

Mr. Crash decided to pursue the posterior approach cervical fusion at C5-6, which was highly successful. The strength in his right upper extremity resumed to normal, the pain decreased in the upper extremity and neck. He regained his cervical range of motion 90% and was able to return to work without the use of opioid medication.

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Workshop Cases

Shoulder Medical Treatment Guidelines Case

OBJECTIVES

1. Describe expected physical therapy for rotator cuff syndrome/impingement. (This should include functional changes expected as the patient improves.)
2. Identify and explain surgical indications for impingement syndrome.
3. Explain pro and cons of steroid injections for impingement.

Instructions : Read the cases below and answer the questions regarding the case. When asked, **cite the recommendations in the Medical Treatment Guidelines**, providing relevant titles, sections and any related information. Credit for your answers will only be given if the appropriate citation is provided. You may refer to the hard-copy version of the guideline or an electronic copy if you are using a tablet or laptop.

Citation Example: Low Back Guidelines p. 42 Sec. F - Therapeutic Procedures- Non-Op, Subsec. 1. b – Acupuncture with E-Stim. May be indicated for certain chronic pain conditions.

Part 1 - Initial report

B.K. is a 45 year old male who has been working in a warehouse over the past three months where his primary job is stocking electrical equipment. He previously worked as an electrician but unfortunately the housing industry crashed and he had to look for alternative employment. Thirty to 50% of the shelves are above his shoulder level and many larger heavier items are stored on the higher shelves. He is experiencing pain and stiffness in his right shoulder, which has been present for approximately the last month and seems to be increasing over the past two weeks. The symptoms of pain, weakness and stiffness have not changed with attempts at rest. He reports that there are functional limitations of using his arm overhead with weakness and catching when the arm is flexed from 60 degrees to 110 degrees. Over the past two weeks, his pain is present at night and radiates down the lateral aspect of the upper arm near the deltoid insertion. There are no neurologic findings. There is no prior history of trauma to the shoulder or previous treatment of the shoulder.

Physical exam: Patient has full passive range of motion but significant pain with active elevation between 60 and 110 degrees. He has poor shoulder mechanics because of weakness of his scapular stabilizers. Resisted tests of shoulder abduction and external rotation also show weakness (50% force output) and causes pain. Special tests include a positive Hawkins and scapular dysfunction with anterior tipping. Pain rating is 4/10 at rest and 7/10 with the resistance of abduction and external rotation.

Q1a. What is the probable diagnosis for this patient? Is there any significance to noting the scapular dysfunction?

Q1b Are any diagnostic tests appropriate at this time? Provide reasoning for your answer by citing the Medical Treatment Guidelines.

Part 2 - Follow-up. On follow-up both active and passive therapy was begun. Patient is working 4 hours/day, only wrist-level activities. X-ray reveals a downward-curved acromion and the attending physician refers to an orthopedist.

Q2. What are the indications for surgery (or not!) in these sections? Justify your answer by citing the Medical Treatment Guideline.

Q3. What conservative therapy should be completed for (a) impingement syndrome or (b) partial tear, before surgery? Provide rationale for your answer using the Treatment Guidelines.

Part 3 - After several weeks, the patient and physician are pleased with the progress thus far. The patient wanted to consider an injection of hyaluronic acid in the subacromial space as the patient had good relief from a previous knee injury with this type of injection.

Q4. What is your recommendation concerning a subacromial injection with hyaluronic acid? Be sure to justify your answer by citing the Medical Treatment Guideline.

Q5. The patient wanted to know about other types of subacromial injections and the benefits of this injection. Cite the Medical Treatment Guideline used to justify your answer.

Part 4 Follow-up: Because the patient had decreased pain at rest and was making progress, it was recommended *not* to do the injection but continue with the physical therapy.

Q6. What goals or objectives should be established with the non-operative management? Please justify your answer with the appropriate medical treatment guideline citation.

Q7. After 8 weeks of therapy, the orthopedist is recommending a distal clavicular resection and an acromioplasty. Are these recommended? Use the medical treatment guidelines to justify your answer.

Bonus question! If surgery is indicated and is accompanied by an interscalene anesthetic block (ISB), would continuous use of ISB be recommended? Justify your answer using the medical treatment guidelines.

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Thoracic Outlet Syndrome

Medical Treatment Guidelines "Mini" Case

OBJECTIVES:

1. Determine the difference between neurologic and arterial TOS.
2. Determine different types of treatment and surgical interventions for TOS.
3. Indicate if botulinum toxin is recommended for the treatment of TOS.

Instructions : Read the cases below and answer the questions regarding the case. When asked, **cite the recommendations in the Medical Treatment Guidelines**, providing relevant titles, sections and any related information. Credit for your answers will only be given if the appropriate citation is provided. You may refer to the hard-copy version of the guideline or an electronic copy if you are using a tablet or laptop.

Citation Example: Low Back Guidelines p. 42 Sec. F - Therapeutic Procedures- Non-Op, Subsec. 1. b – Acupuncture with E-Stim. May be indicated for certain chronic pain conditions.

Case Example:

A patient has classical neurologic symptoms of thoracic outlet syndrome:

- Numbness in the 4th and 5th digits.
- Tenderness over the scalene muscles
- Elevated arm stress test (EAST) and increased symptoms with head tilting.

Q1. What should be performed at the work site in regard to treatment? Please cite from the Medical Treatment Guidelines to justify your answer.

Q2. Would an injection of Botulinum toxin be an option? Provide rationale for your answer by citing the Medical Treatment Guideline.

Q3. When is surgery appropriate? Justify your answer by citing the Medical Treatment Guidelines used.

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References

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

PHYSICIAN'S REPORT OF WORKER'S COMPENSATION INJURY

A COPY OF THIS REPORT MUST BE SENT TO THE INJURED WORKER AND THE INSURER.

1. REPORT TYPE ☐ Initial ☐ Progress ☐ Closing **EXAM DATE** _____

2. CASE INFORMATION

Date of Injury _____ Insurer Claim # _____
Injured Worker _____ Insurer Name/TPA _____
Social Security # _____ Insurer Phone/Fax _____
Date of Birth _____ Employer Name _____

3. INITIAL VISIT (only)

a. Injured worker's description of accident/injury

b. Are your objective findings consistent with history and/or work-related mechanism of injury/illness? ☐ Yes ☐ No

4. CURRENT WORK STATUS ☐ Working ☐ Not Working

5. WORK-RELATED MEDICAL DIAGNOSIS(ES) _____

6. PLAN OF CARE

a. TREATMENT PLAN

☐ Diagnostic tools/tests _____
☐ Procedures _____
☐ Therapy _____
☐ Medications _____
☐ Supplies _____
☐ Other _____

b. WORK STATUS

☐ Able to return to full duty on _____
☐ Able to return to modified duty from _____ to _____
☐ Unable to work from _____ to _____
☐ Able to return to part time work on _____ for _____ hours per day

c. LIMITATIONS/RESTRICTIONS ☐ No Restrictions ☐ Temporary Restrictions ☐ Permanent Restrictions

☐ Lifting (maximum weight in pounds) _____ lbs.		☐ Walking _____	hours per day
☐ Repetitive lifting _____ lbs.		☐ Standing _____	hours per day
☐ Carrying _____ lbs.		☐ Sitting _____	hours per day
☐ Pushing / Pulling _____ lbs.		☐ Crawling _____	hours per day
☐ Pinching / Gripping _____		☐ Kneeling _____	hours per day
☐ Reaching over head		☐ Squatting _____	hours per day
☐ Reaching away from body		☐ Climbing _____	hours per day

☐ Repetitive Motion Restrictions _____
☐ Other _____

7. FOLLOW UP CARE AND REFERRALS - *7c. requires a notice by certified mail to insurer & patient within 3 business days. (See Instructions)

a. ☐ Return Appointment Date _____

b. ☐ Referral for ☐ Treatment (specify) _____ ☐ Evaluation (specify) _____
☐ Impairment Rating _____ ☐ Other (specify) _____
Referred Provider's Name _____ Phone # _____

c. ☐ Discharged for Non-Compliance* ☐ Discharged from Care for Nonmedical Reasons*

8. MAXIMUM MEDICAL IMPROVEMENT (MMI)

☐ Injured Worker has reached MMI Date of MMI _____
☐ Injured Worker is not at MMI, but is anticipated to be at MMI in/on _____
☐ MMI date unknown at this time because _____

9. MAINTENANCE CARE AFTER MMI ☐ Yes ☐ No
If yes, specify care:

10. PERMANENT MEDICAL IMPAIRMENT (REQUIRED)

☐ No permanent impairment ☐ Permanent Impairment (attached required worksheets and narrative)
☐ Anticipate permanent impairment ☐ Needs referral to Level II physician for impairment rating (see 7b above)

11. PHYSICIAN'S SIGNATURE _____ Date of Report _____

Print Name _____ License # _____ Phone # _____

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PHYSICIAN'S REPORT OF WORKER'S COMPENSATION INJURY
INSTRUCTIONS / DEFINITIONS

This form is required by the Workers' Compensation Rules of Procedure *Rule 16-7(E)(1), 7 CCR 1101-3* to report all information specific to this workers' compensation injury.

Complete all applicable fields and attach your narrative report that further describes and supports your findings. Your narrative report does not replace this form.

1. **Report Type and Exam Date:** Check "Initial" if this is the first visit related to this described injury. Check "Progress" when a change in condition, diagnosis, or treatment occurs. Check "Closing" if the injured worker is at MMI, requires an impairment rating, or is discharged from care. On "Exam Date," include the date of the office visit, if applicable.

2. **Case Information:**
   - **Date of Injury:** Date of this injury.
   - **Injured Worker:** Name of the injured worker.
   - **Social Security #:** The injured worker's social security number.
   - **Date of Birth:** The injured worker's date of birth.
   - **Insurer Claim #:** The name of the insurance carrier or self-insured employer associated with the claim.
   - **Employer Name:** The name of the employer associated with the claim.

3. **Initial Visit:**
   a. Describe how the accident or injury occurred in the injured worker's words.
   b. Check the applicable box regarding physician's objective findings.

4. **Current Work Status:** Current work status as related by injured worker.

5. **Work-Related Medical Diagnosis(es):** State the injured worker's work-related medical diagnosis(es).

6. **Plan of Care:**
   a. **Treatment Plan:** Complete all applicable portions regarding treatment. Indicate frequency and duration.
      - **Diagnostic tools/tests:** EMG, MRI, CT-scan, etc.
      - **Procedures:** Any medical procedure including surgical procedures, castings, etc.
      - **Therapy:** Physical therapy, occupational therapy, home exercise, etc. Include plan specifications.
      - **Medications:** Antibiotics, analgesics, anti-inflammatory drugs, etc.
      - **Supplies:** Durable medical equipment, splints, braces, etc.
      - **Other:** Any treatment not covered above.
   b. **Work Status:** Check the applicable work status box(es). List date(s) and hours as appropriate.
   c. **Limitations/Restrictions:** Check the applicable box(es) regarding any medical or physical limitations or restrictions including temporary or permanent restrictions.

7. **Follow-up Care and Referrals:**
   a. Provide the date of the next scheduled appointment
   b. If a referral was made to another provider, supply that provider's name and phone number. Designate who is to make the referral appointment.
   c. If the authorized physician refuses to provide medical treatment to an injured worker or discharges the injured worker from medical care for nonmedical reasons when the injured worker requires medical treatment to cure and relieve the effects of the work injury, then the physician must, within three (3) business days from the refusal or discharge, provide written notice of the refusal or discharge by certified mail, return receipt requested, to the injured worker and insurer. The notice must explain the reasons for the refusal or discharge and must offer to transfer the injured worker's medical records to any new authorized physician upon receipt of a signed authorization to do so from the injured worker. For a template letter, flowchart, and information on reimbursement, refer to Desk Aid #15 on the Division website.

8. **Maximum Medical Improvement (MMI):** Check the applicable box(es). List additional information as appropriate. MMI means a point in time when any impairment resulting from the injury has become stable and when no further treatment is reasonably expected to improve the condition.

9. **Maintenance Care after MMI:** In some cases, MMI may be unknown because the injured worker has not returned for care.

10. **Permanent Medical Impairment:** Check the applicable box(es). If the injury will cause a permanent impairment, an impairment rating performed by a Level II accredited physician is required. If an impairment rating is given, attach the worksheets required by the Division and a report describing the extent of the injured worker's impairment rating.

11. **Physician Information:** List the name, license number, and telephone number of the physician responsible for the report. **The physician responsible for the report must sign and date the report.**

WC164 Rev. 11/14

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

AUTHORIZED TREATING PROVIDER'S REQUEST FOR PRIOR AUTHORIZATION

Please fill out all required information, as missing information may delay your request.

Date of Injury:	***Patient's DOB:***	***Carrier Claim #:***	***Date Sent:***
Patient's Name: Last	First		MI
Insurance Carrier's/Agent's Name:			
Address: Number and Street	City	State	Zip Code
Telephone Number:	*Fax Number:*		

AUTHORIZED TREATING PROVIDER REQUESTING PRIOR AUTHORIZATION

Provider's Name:	*Telephone Number:*	*Fax Number:*	*NPI/FEIN:*
Address: Number and Street		City	State / Zip Code

AUTHORIZATION REQUESTED/STATEMENT OF MEDICAL NECESSITY

Specify service(s) and billing code(s):	Dx/ICD-9 Codes:

Medical Justification for the requested procedure(s) or for treatment beyond guideline recommendation (Rule 17):

Supporting documentation attached: ☐

If establishing reimbursement for By Report (BR) or Relativity Not Established (RNE), please describe required procedure; give recommended payment based on requested code(s) with justification for payment:

Supporting documentation attached: ☐

I certify that this request was sent to: Ordering Provider or Representative: Signature: Date:	Submitted by: ☐ Mail ☐ Fax: ( ) ☐ Email:

The self-insured employer or employee's insurance carrier shall respond with their required information (noted in the grey shaded areas) within seven (7) business days from receipt of the provider's completed request. Per Rule 16-9(C), requests delayed beyond seven (7) days will be deemed automatically approved.	**Date Received:**
A denial of authorization must be completed in accordance with the procedures as outlined in Rule 16-10(A) *Contest of Prior Authorization for Non-Medical Reasons* or 16-10(B) *Contest of Prior Authorization for Medical Reasons* and the payer must clearly identify whether granting or denying prior authorization for the services requested on this form.	Payer Response to Medical Service/Procedure request: Granted (please provide authorization code):

Medical reasons for denial(s) of any request for prior authorization require a medical opinion/review in accordance with Rule 16-10(B) and Rule 17, applicable Treatment Guidelines to be attached to this response form.

I certify that copies of the approval/denial were completed and sent to the health care provider, the injured worker, and the injured worker's legal counsel on the date below:

By: *(Print Name)* **Signature:**	Title: Date:

WC 188 Rev. 09/12

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COLORADO DEP R AND EMPLOYMENT
Division of Workers' Compensation

NOTIFICATION BY AN AUTHORIZED TREATING PROVIDER

NOTIFICATION IS FOR TREATMENT CONSISTENT WITH THE MEDICAL TREATMENT GUIDELINES

Please fill out all required information, as missing information may delay your request

Date of Injury	**Patient's DOB**	**Carrier Claim #**	**Date Sent**

Patient's Name: Last First M.I.

Insurance Carrer's/Agent's Name

Address: Number and Street City State Zip Code

AUTHORIZED TREATING PROVIDER SUBMITTING NOTIFICATION

Provider's Name	Phone #	Fax # OR Email	NPI/FEIN

Address: Number and Street City State Zip Code

CERTIFICATION THE PRESCRIBED TREATMENT IS WITHIN THE MEDICAL TREATMENT GUIDELINES

Specify treatment/service(s) and billing code(s) Dx/ICD-10 Code

Identification of the specific Medical Treatment Guideline applicable to the prescribed treatment/service (Rule 17):

Guideline Section

Supporting documentation attached

I certify that the prescribed treatment is medically necessary and within the Medical Treatment Guidelines.

ATP's Signature Date

TO BE COMPLETED BY THE CARRIER. Per Rule 16-9, the self-insured employer or employer's insurance carrier shall respond with their required information (noted in the gray shaded areas) within five (5) business days from receipt of the provider's notification.

Form is incomplete

Notification Confirmed; Authorization #_____

Approval limited in accordance with MTG as follows:_____

Notification Denied for the following reason(s):

- No admission of liability or final order finding the injury compensable has been issued (for reported claims).
- Proposed treatment is not related to the admitted injury.
- Provider submitting Notification is not an ATP or is proposing for treatment to be performed by a non-eligible ATP.
- Injured worker is not entitled to proposed treatment pursuant to statute or settlement.
- Medical records contain conflicting opinions among the ATPs regarding proposed treatment.
- The prescribed treatment falls outside of the Medical Treatment Guidelines and will be reviewed as a Prior Authorization. (additional information requested)

I certify that copies of the confirmation/denial were completed and sent to the health care provider on the date below:

By (Print Name) Signature Title Date

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Chiropractic Code of Ethics

Note: The Code of Ethics of the American Chiropractic Association as reproduced here may be found at the ACA's webpage, at www.acatoday.com/content_css.cfm?CID=719

Or, contact the American Chiropractic Association at 1-800-986-4636.

PREAMBLE

This Code of Ethics is based upon the acknowledgement that the social contract dictates the profession's responsibilities to the patient, the public, and the profession; and upholds the fundamental principle that the paramount purpose of the chiropractic doctor's professional services shall be to benefit the patient.

I. Doctors of chiropractic should adhere to a commitment to the highest standards of excellence and should attend to their patients in accordance with established best practices.

II. Doctors of chiropractic should maintain the highest standards of professional and personal conduct, and should comply with all governmental jurisdictional rules and regulations.

III. Doctor-patient relationships should be built on mutual respect, trust and cooperation. In keeping with these principles, doctors of chiropractic shall demonstrate absolute honesty with regard to the patient's condition when communicating with the patient and/or representatives of the patient. Doctors of chiropractic shall not mislead patients into false or unjustified expectations of favorable results of treatment. In communications with a patient and/or representatives of a patient, doctors of chiropractic should never misrepresent their education, credentials, professional qualification or scope of clinical ability.

IV. Doctors of chiropractic should preserve and protect the patient's confidential information, except as the patient directs or consents, or the law requires otherwise.

V. Doctors of chiropractic should employ their best good faith efforts to provide information and facilitate understanding to enable the patient to make an informed choice in regard to proposed chiropractic treatment. The patient should make his or her own determination on such treatment.

VI. The doctor-patient relationship requires the doctor of chiropractic to exercise utmost care that he or she will do nothing to exploit the trust and dependency of the patient. Sexual misconduct is a form of behavior that adversely affects the public welfare and harms patients individually and collectively. Sexual misconduct exploits the doctor-patient relationship and is a violation of the public trust.

VII. Doctors of chiropractic should willingly consult and seek the talents of other health care professionals when such consultation would benefit their patients or when their patients express a desire for such consultation.

VIII. Doctors of chiropractic should never neglect nor abandon a patient. Due notice should be afforded to the patient and/or representatives of the patient when care will be withdrawn so that appropriate alternatives for continuity of care may be arranged.
IX. With the exception of emergencies, doctors of chiropractic are free to choose the patients they will serve, just as patients are free to choose who will provide healthcare services for them. However, decisions as to who will be served should not be based on race, religion, ethnicity, nationality, creed, gender, handicap or sexual preference.

X. Doctors of chiropractic should conduct themselves as members of a learned profession and as members of the greater healthcare community dedicated to the¬ promotion of health, the prevention of illness and the alleviation of suffering. As such, doctors of chiropractic should collaborate and cooperate with other health care professionals to protect and enhance the health of the public with the goals of reducing morbidity, increasing functional capacity, increasing the longevity of the U.S. population and reducing health care costs.

XI. Doctors of chiropractic should exercise utmost care that advertising is truthful and accurate in representing the doctor's professional qualifications and degree of competence. Advertising should not exploit the vulnerability of patients, should not be misleading and should conform to all governmental jurisdictional rules and regulations in connection with professional advertising.

XII. As professions are self-regulating bodies, doctors of chiropractic shall protect the public and the profession by reporting incidents of unprofessional, illegal, incompetent and unethical acts to appropriate authorities and organizations and should stand ready to testify in courts of law and in administrative hearings.

XIII. Doctors of chiropractic have an obligation to the profession to endeavor to assure that their behavior does not give the appearance of professional impropriety. Any actions which may benefit the practitioner to the detriment of the profession must be avoided so as to not erode the public trust.

XIV. Doctors of chiropractic should recognize their obligation to help others acquire knowledge and skill in the practice of the profession. They should maintain the highest standards of scholarship, education and training in the accurate and full dissemination of information and ideas.

The ACA's Code of Ethics was revised and ratified by the ACA House of Delegates September 2007.

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AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE

The Seven Ethical Principles of Occupational and Environmental Medicine

Occupational and environmental health professionals have an obligation to…

1. Promote a Safe and Healthy Workplace Environment

Acknowledge primary responsibility for the health and safety of the individual, as well as worker populations, and take affirmative measures to ensure health and safety in the workplace.

2. Uphold Ethical Standards

Behave honestly and ethically in all professional relationships, actively resisting and striving to correct unethical conduct. Recognize and acknowledge impairments that interfere with the ability to follow this Code and take appropriate measures to ameliorate them and restricting practice until remediation is accomplished.

3. Avoid Discrimination

Build a relationship of trust and confidence with the people for whom they provide services, treating all in an equitable manner, without any form of discrimination. Identify and overcome bias or stereotypes which may affect medical care and decision making both in individual patients and in the populations served.

4. Maintain Professional Competence

Maintain individual competence and expertise based on current scientific evidence and technical knowledge, remaining engaged in life-long learning regarding work and the environments of those whom they serve and applying appropriate methods to eliminate or minimize risks and recognizing when to call upon specialized expert advice.

5. Protect Patient Confidentiality

Keep confidential all individual medical, health promotion, and health screening information, only releasing such information with proper authorization. Recognize that employers may be entitled to counsel about an individual's medical work fitness.

6. Advise and Report

Communicate effectively and in a timely manner to an individual all significant observations about the health and health risk of that person and provide advice about interventions available to restore, sustain, and improve health or prevent illness. While respecting confidentiality, report findings and observations of health effects in individuals and populations to those in a position to take appropriate action.

7. Address Conflict of Interest

Ensure ethical conduct regarding conflicts of interest by recognizing, acknowledging, and appropriately addressing any secondary interests that might in reality distort the integrity of judgments or be perceived to do so. Ethical practice must ensure that harm does not accrue as a result of such conflicts.

Approved by the ACOEM Board of Directors, April 2010

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Confidentiality of Medical Information in the Workplace

Tuesday, November 06, 2012

ACOEM Committee on Ethical Practice in Occupational and Environmental Medicine

As do all physicians, occupational and environmental medicine (OEM) practitioners rely on the patient to completely and truthfully disclose private information before rendering a professional opinion. In order to facilitate the disclosure of private personal information, employees must feel that their private disclosures will be treated in a dignified and confidential manner. Because a physician must first of all do no harm, information received in confidence should be disclosed only when it is in the best interests of the patient or society, or required by applicable law or valid governmental rule or regulation.

When considering requests for job accommodation, addressing threats to health or safety, or reviewing claims for workers' compensation benefits, employers may require access to personal information. Additionally, employers shoulder an increasing responsibility for providing other types of benefits such as health and disability insurance, family medical leave, and employee assistance programs. As a result, the employer becomes inextricably and unavoidably involved in employees' personal and medical affairs. Thus, competing interests between the employee's right to privacy and the employer's legitimate interest in the health of the employee creates sensitive ethical and legal dilemmas for physicians who practice occupational medicine. Other parties, such as insurers, state and federal agencies, and accrediting organizations may also have a right to patient records, and this right must be considered and managed carefully.

The laws governing the confidentiality of employee medical information are complex and vary depending on the relationship between parties and by jurisdiction.[1] Difficult ethical problems arise when the physician must attempt to balance the importance of the employee's need and legal right to keep information confidential versus the employer's need and legal right to know or the interests of other parties.

ACOEM Position

The American College of Occupational and Environmental Medicine (ACOEM) acknowledged the importance of medical confidentiality with publication of its first Code of Ethical Conduct in 1976. This Code was later revised in 1993 to reflect changes in the character of the modern workplace,[2] and subsequently updated in 2010.[3] The 2010 Code of Ethics states that physicians should:

"5. Protect Patient Confidentiality. Keep confidential all individual medical, health promotion, and health screening information, only releasing such information with proper authorization. Recognize that employers may be entitled to counsel about an individual's medical work fitness."[3]

Additional Guidance on Medical Confidentiality in the Workplace

While the ACOEM Code of Ethics provides direction, the ACOEM Committee on Ethical Practice in Occupational and Environmental Medicine believes that additional guidance on the issue of confidentiality is necessary. Therefore, in addition to Point 5 of the ACOEM Code of Ethics, the College is providing the following guidance regarding medical record confidentiality:

1. Legislation and local practice may treat medical records created in the context of occupational health, independent medical evaluations, and workers' compensation cases differently from medical records created by personal health care providers. However, the physician practicing occupational medicine is advised not to make such distinctions in practice without clear legal guidance or permission from the proper parties. Confidential medical information should be treated the same as in situations where there is a clear physician-patient relationship unless there is a valid legal reason or consent to do otherwise, a health and safety risk to the client or others, or evidence of a criminal act.[4]

2. Physicians should make all reasonable efforts to obtain the patient's consent before disclosing all or any portion of his or her medical record. If disclosure is legally required or consent is not legally required, the patient should be notified of the impending disclosure unless such notification is impossible or there are overriding patient or public health concerns.

3. Physicians should recognize a patient's consent-for-disclosure only if said consent is both informed and voluntary. The consent should specify the nature of the information to be released, the purposes for its release, the person or persons to whom it may be released, the time period for which the consent remains in effect, and acknowledgement statement that the patient may rescind consent at anytime. The consent must be signed by the employee or his or her legal guardian, or if the employee is deceased, by his or her personal representative.

4. Whenever physicians are aware that the results of an examination or records of a visit may be shared with a third party (e.g., in the case of an independent medical examination the information will be shared with an insurer and/or attorneys representing the insurer and the claimant), it is incumbent upon the physician to properly notify the examinee prior to gathering historical or clinical data as to the nature of the evaluation, what information will be collected, and to whom it will be transmitted. The physician should not state or imply that any records will be kept confidential if this cannot be assured. The physician performing independent medical examinations should be knowledgeable of statutes and/or regulations controlling the distribution of their reports. It is appropriate that the insurer and physician share with the claimant the nature of information to be included and the distribution of the report. Sensitive confidential medical information that is not relevant to the claim should not be included in the report.

5. Although all personal health information should be presumed to be confidential, physicians should recognize that certain types of health information are particularly sensitive such as sexual orientation, HIV/AIDS status,[5] drug and alcohol treatment, past history of physical or sexual abuse, treatment for sexually transmitted diseases, and genetic information.[6] Physicians should be aware that a general consent for disclosure of medical records cannot be presumed to be sufficient in these situations and that specific written consent for release of such information must be obtained. This information should only be

disclosed in compliance with U.S. federal and state law and similar laws of other countries where occupational physicians work. Because it is often possible to infer sensitive information from other parts of the medical record, such as the medication history, the physician should treat such information in the same manner as explicitly sensitive information.

6. Physicians should release only the portion of a record covered by a release and not disclose the entire medical record unless indicated and permitted by the patient. Forwarding records that have been obtained from other medical providers is appropriate when that information is relevant to the specific problem in question and permitted.

7. Physicians should develop a written policy for the treatment of medical records in their offices, clinics, or workplaces. The policy should address such issues as where, and for how long the records are stored; the security of medical records including computer databases; what happens in the event of employee resignation, layoff, termination, job transfer, or closure and/or merger of employer; and the mechanisms of employee access and consent for disclosure.[7]

8. Physicians should make reasonable efforts to ensure that those under their supervision act with due care regarding the confidentiality of medical records, and act to educate fellow health care providers and office support staff regarding the confidentiality of medical information. Physicians should encourage the confidential treatment of medical information by their clients and in their organization by colleagues in other departments such as human resources or benefits who may have access to such data.

9. Physicians should disclose their professional opinion to both the employer and the employee when the employee has undergone a medical assessment for fitness to perform a specific job. However, the physician should not provide the employer with specific medical details or diagnoses unless the employee has given his or her permission. Additionally, physicians should not disclose without permission any “non-medical” information gained in the context of a physician/patient relationship that could adversely affect the employee. Exceptions include health and safety concerns or knowledge of unlawful activity.

10. Physicians should notify employees of their right to obtain access to their medical records and to request correction of any inaccuracies therein.[8]

11. Supervisors and managers may be informed regarding necessary restrictions on the work or duties of the employee and recommended accommodations. First aid and safety personnel may be informed, when appropriate, if a condition might require emergency treatment, in which case the employee should be informed.

12. Physicians should be a source of professional, unbiased, and expert opinion in the workers’ compensation or court systems and should only disclose medical information that is relevant and necessary to the claim or suit. When release of medical information is authorized or required by specific regulation, only the necessary and relevant information should be released.

13. Physicians should exercise caution whenever presented with a request or subpoena for medical records that does not include a written authorization for release by the employee, or when the records requested contain information about HIV status, drug and alcohol

treatment, or genetic information. It may be appropriate to seek legal advice in these situations.

14. Physicians should withdraw or decline services when faced with an irresolvable ethical conflict or an unethical request by a client or employer. In many instances, the medical record will be the property of an employer. This ownership does not abrogate any of these principles. Each employer that owns medical records should designate a custodian of the records. Access by employer officials (e.g., employee relations, legal counsel) should proceed via the same process as requests by those outside the employer through the custodian. Physicians should consider inquiring about the employer's practices regarding medical records prior to employment or contractual services.

Because OEM physicians work in a wide variety of practice situations and must respect the laws and customs of many countries, physicians have an ethical duty to become familiar with laws and regulation applicable to their practice. The College believes that all employee health and medical records should be treated as confidential by the employer and provider; however, occupational medicine physicians are in a unique position and must carefully balance the interests of all parties and society as a whole. These recommendations are intended to serve as guidance for OEM physicians in their relationships with their patients and the other individuals that they serve including employers.

References

1. Rischitelli DG. The confidentiality of medical information in the workplace. *J Occup Environ Med*. 1995;37(5):583-93.
2. Teichman R, Wester MS. Code of ethical conduct. *J Occup Med*. 1994;29(1):27-30.
3. ACOEM Code of Ethics. 2010. Available at www.acoem.org/codeofconduct.aspx.
4. American Medical Association Council on Ethical and Judicial Affairs. *Code of Medical Ethics. Current Opinions with Annotations*. Chicago, Ill: AMA, 2006.
5. Americans with Disabilities Act, 42 USC §12112(D)(3)(B) (1990).
6. ACOEM Task Force on Genetic Screening in the Workplace. Position statement. Genetic screening in the workplace. *J Occup Environ Med*. 2010;52(7):763. Available at www.acoem/org/GeneticScreening.aspx.
7. Health Insurance Portability and Accountability Act of 1996 (HIPAA). *Federal Register*. 65 FR 82462. December 28, 2000. Available at www.hhs.gov/ocr/hipaa/finalreg.html.
8. OSHA. Access to Employee Exposure and Medical Records Standard. 19 CFR § 1910.20.

This statement was reviewed and revised by the ACOEM Committee on Ethical Practice in Occupational and Environmental Medicine. Committee members are Drs. David Lukcso, chair, Paul Brandt-Rauf, and William W. Greaves. This statement was peer-reviewed by Dr. Robert Orford, and approved by the ACOEM Board of Directors on July 28, 2012. This statement updates ACOEM's 2008 statement.

Psychological Evaluations

PATIENT HEALTH QUESTIONNAIRE (PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name_____ **Age**_____ **Sex:** ☐ **Female** ☐ **Male** **Today's Date**_____

1. During the last 4 weeks, how much have you been bothered by any of the following problems?		**Not bothered**	**Bothered a little**	**Bothered a lot**
a.	Stomach pain	☐	☐	☐
b.	Back pain	☐	☐	☐
c.	Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
d.	Menstrual cramps or other problems with your periods	☐	☐	☐
e.	Pain or problems during sexual intercourse	☐	☐	☐
f.	Headaches	☐	☐	☐
g.	Chest pain	☐	☐	☐
h.	Dizziness	☐	☐	☐
i.	Fainting spells	☐	☐	☐
j.	Feeling your heart pound or race	☐	☐	☐
k.	Shortness of breath	☐	☐	☐
l.	Constipation, loose bowels, or diarrhea	☐	☐	☐
m.	Nausea, gas, or indigestion	☐	☐	☐

2. Over the last 2 weeks, how often have you been bothered by any of the following problems?		**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
a.	Little interest or pleasure in doing things	☐	☐	☐	☐
b.	Feeling down, depressed, or hopeless	☐	☐	☐	☐
c.	Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d.	Feeling tired or having little energy	☐	☐	☐	☐
e.	Poor appetite or overeating	☐	☐	☐	☐
f.	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g.	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h.	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i.	Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

FOR OFFICE CODING: Som Dis if at least 3 of #1a-m are "a lot" and lack an adequate biol explanation.
Maj Dep Syn if answers to #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all).
Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all).

		NO	YES
6. Questions about eating.			
a.	Do you often feel that you can't control what or how much you eat?	☐	☐
b.	Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food?	☐	☐
If you checked "NO" to either #a or #b, go to question #9.			
c.	Has this been as often, on average, as twice a week for the last 3 months?	☐	☐

		NO	YES
7. In the last 3 months have you often done any of the following in order to avoid gaining weight?			
a.	Made yourself vomit?	☐	☐
b.	Took more than twice the recommended dose of laxatives?	☐	☐
c.	Fasted — not eaten anything at all for at least 24 hours?	☐	☐
d.	Exercised for more than an hour specifically to avoid gaining weight after binge eating?	☐	☐

		NO	YES
8. If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?		☐	☐

		NO	YES
9. Do you ever drink alcohol (including beer or wine)?		☐	☐
If you checked "NO" go to question #11.			

		NO	YES
10. Have any of the following happened to you more than once in the last 6 months?			
a.	You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health.	☐	☐
b.	You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities.	☐	☐
c.	You missed or were late for work, school, or other activities because you were drinking or hung over.	☐	☐
d.	You had a problem getting along with other people while you were drinking.	☐	☐
e.	You drove a car after having several drinks or after drinking too much.	☐	☐

11. If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

FOR OFFICE CODING: Bul Ner if #6a,b, and-c and #8 are all 'YES'; Bin Eat Dis the same but #8 either 'NO' or left blank.
Alc Abu if any of #10a-e is 'YES'.

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INSTRUCTION MANUAL
Instructions for Patient Health Questionnaire (PHQ) and GAD-7 Measures

BACKGROUND

The Primary Care Evaluation of Mental Disorders (PRIME-MD) was an instrument developed and validated in the early 1990s to efficiently diagnose five of the most common types of mental disorders presenting in medical populations: depressive, anxiety, somatoform, alcohol, and eating disorders.[1] Patients first completed a one-page 27-item screener and, for those disorders for which they screened positive, were asked additional questions by the clinician using a structured interview guide. However, this 2-stage process took an average of 5-6 minutes of clinician time in patients without a mental disorder diagnosis and 11-12 minutes in patients with a diagnosis. This proved to be a barrier to use given the competing demands in busy clinical practice settings.

Therefore, in two large studies enrolling 6000 patients (3000 from general internal medicine and family practice clinics and 3000 from obstetrics-gynecology clinics), a self-administered version of the PRIME-MD called the Patient Health Questionnaire (PHQ) was developed and validated.[2,3] In the past decade, the PHQ in general and the PHQ-9 depression scale in particular [4-6] have gained increasing use in both research and practice. The original PRIME-MD is now largely of historical interest and seldom used except in a few types of research studies.

Given the popularity of the PHQ-9 for assessing and monitoring depression severity, a new 7-item anxiety scale using a response set similar to the PHQ-9 was initially developed to diagnose generalized anxiety disorder (hence its name, the GAD-7) and validated in 2740 primary care patients.[7] Though originally developed to diagnose

generalized anxiety disorder, the GAD-7 also proved to have good sensitivity and specificity as a screener for panic, social anxiety, and post- traumatic stress disorder.[8] Finally, the PHQ-15 was derived from the original PHQ studies and is increasingly used to assess somatic symptom severity and the potential presence of somatization and somatoform disorders. [9]

Each PHQ module can be used alone (e.g. the PHQ-9 if depression is the condition of interest), together with other modules, or as part of the full PHQ. Also, alternative or abbreviated versions of the PHQ-9 and GAD-7 are sometimes used in certain screening or research settings [10-14] Although the PHQ was originally developed to detect five disorders, the depression, anxiety, and somatoform modules (in that order) have turned out to be the most popular.[10] Also, most primary care patients with depressive or anxiety disorders present with somatic complaints and co- occurrence of somatic, anxiety, and depressive symptoms (the *SAD* triad) is exceptionally common. This is the rationale behind the PHQ-SADS screener.[15] The most commonly used versions of the PHQ scales are summarized in Table 1, page 3.

CODING AND SCORING

The full PHQ, Brief PHQ, and PHQ for Adolescents (PHQ-A) can be used to establish provisional diagnoses for selected DSM-IV disorders. The diagnostic algorithm for the PHQ modules are included in footers at the bottom of each page of the PHQ, and also reiterated in Table 2, page 4. The other measures are principally used to derive severity scores (PHQ-9 and PHQ-8 for depressive symptom severity; GAD-7 for anxiety symptom severity; PHQ-15 for somatic symptom severity) or as ultra-brief screeners (PHQ-2, GAD-2, PHQ-4). An example in which the PHQ depression module can be used as both a diagnostic module as well as a depression severity score (PHQ-9 score) is shown in Table 3, page 5.

Over time, the severity scores have been a particularly popular use of the measures, and are now used much more commonly than the provisional diagnoses. For example, cut points of 5, 10, and 15 represent mild, moderate, and severe levels of depressive, anxiety, and somatic symptoms, on the PHQ-9, GAD-7, and PHQ-15 respectively. Also, a cut point of 10 or greater is considered a “yellow flag” on all 3 measures (i.e., drawing attention to a possible clinically significant condition), while a cut point of 15 is a “red flag” on all 3 measures (i.e., targeting individuals in whom active treatment is probably warranted). For the ultra-brief measures (PHQ-2 and GAD-2), a score of 3 or greater should prompt administration of the full PHQ-9 and/or GAD-7, as well as a clinical interview to determine whether a mental disorder is present.

The final question on the PHQ (and some of its abbreviated versions) asks the patients to report “how” difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?” This single patient-rated difficulty item is not used in calculating any PHQ score or diagnosis but rather represents the patient‘s global impression of symptom-related impairment. It may be useful in decisions

regarding initiation of or adjustments to treatment since it is strongly associated with both psychiatric symptom severity as well as multiple measures of impairment and health-related quality of life.

A particularly important question is how to assess suicide risk in individuals who answer positively to the 9th question of the PHQ-9. A four-item screener has been developed that may assist in positive responses to this 9th question [16], although a final decision about the actual risk of self-harm requires a clinical interview.

Table 1. Versions: Patient Health Questionnaire (PHQ) Family of Measures

Measure	Description	Scoring	References
Core			
PRIME-MD	Predecessor of PHQ, now mainly of historical interest.	Combined self-administered patient screener with clinician follow-up questions.	1
PHQ	Five modules covering 5 common types of mental disorders: depression, anxiety, somatoform, alcohol, and eating.	Selected (but provisional) DSM-IV diagnoses for all types of disorders except somatoform.	2, 3
PHQ-9	Depression scale from PHQ.	Nine items, each of which is scored 0 to 3, providing a 0 to 27 severity score.	1, 4, 5, 6, 10
GAD-7	Anxiety measure developed after PHQ but incorporated into PHQ-SADS.	Seven items, each of which is scored 0 to 3, providing a 0 to 21 severity score.	7, 8, 10
PHQ-15	Somatic symptom scale from PHQ.	Fifteen items, each of which is scored 0 to 2, providing a 0 to 30 severity score.	9, 10
PHQ-SADS	PHQ-9, GAD-7, and PHQ-15 measures, plus panic measure from original PHQ.	See scoring for these scales above.	10
Variants			
Brief PHQ	PHQ-9 and panic measures from original PHQ plus items on stressors and women's health.	See scoring for PHQ above. Stressor and women's health items are not diagnostic or scored.	3
PHQ-A	Substantially modified version of PHQ developed for use in adolescents. Moderate data exists for validity but much less than for original PHQ.	Diagnostic scoring described in manual, available upon request.	11
PHQ-2	First 2 items of PHQ-9. Ultra-brief depression screener.	Two items scored 0 to 3 (total score of 0-6)	10, 12
GAD-2	First 2 items of GAD-7. Ultra-brief anxiety screener.	Two items scored 0 to 3 (total score of 0-6)	8, 10, 12
PHQ-4	PHQ-2 and GAD-2.	See PHQ-2 and GAD-2 above.	10, 12, 13
PHQ-8	All items of PHQ-9 except the 9th item on self-harm. Mainly used in non-depression research studies.	Eight items, each of which is scored 0 to 3, providing a 0 to 24 severity score.	5, 10, 14

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Table 2. Diagnostic Algorithms for the PHQ

Page 1

Somatoform Disorder if at least 3 of #1a-m bother the patient "a lot" and lack an adequate biological explanation.

Major Depressive Syndrome if #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all) .

Other Depressive Syndrome if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all).

Note**:** the diagnoses of Major Depressive Disorder and Other Depressive Disorder requires ruling out normal *bereavement (mild symptoms, duration less than 2 months***)**, a history of a *manic* episode (Bipolar Disorder) and a *physical disorder, medication or other drug* as the biological cause of the depressive symptoms.

Page 2

Panic Syndrome if #3a-d are all 'YES' and 4 or more of #4a-k are YES'.

Other Anxiety Syndrome if #5a and answers to three or more of #5b-g are "More than half the days".

Note**:** The diagnoses of Panic Disorder and Other Anxiety Disorder require ruling out a *physical disorder***,** *medication or other drug* as the biological cause of the anxiety symptoms.

Page 3

Bulimia Nervosa if #6a,b, and c and #8 are YES';

Binge Eating Disorder the same but #8 is either 'NO' or left blank.

Alcohol abuse if any of #10a-e are "YES".

Additional Clinical Considerations. After making a provisional diagnosis with the PHQ, there are additional clinical considerations that may affect decisions about management and treatment.

- Have current symptoms been triggered by psychosocial **stressor(s**)?
- What is the **duration** of the current disturbance and has the patient received any **treatment** for it?
- To what extent are the patient's symptoms i**mpairing** his or her usual work and activities?
- Is there a **history** of similar episodes, and were they **treated**?
- Is there a history of there a family history of similar conditions?

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Table 3. Example of PHQ Depression Module for both Diagnostic and Severity Purposes

Patient: A 43-year-old woman who looks sad and complains of fatigue for the past month.

2. Over the last 2 weeks, how often have you been bothered by any of the following:	Not at all	Several days	More than half the days	Nearly every day
	(0)	(1)	(2)	(3)
a. Little interest or pleasure in doing things?	☐	☐	☐	☒
b. Feeling down, depressed, or hopeless?	☐	☒	☐	☐
c. Trouble falling or staying asleep, or sleeping too much?	☐	☐	☒	☐
d. Feeling tired or having little energy?	☐	☐	☐	☒
e. Poor appetite or overeating?	☐	☒	☐	☐
f. Feeling bad about yourself—or that you are a failure or have let yourself or your family down?	☐	☐	☒	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television?	☐	☐	☐	☒
h. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?	☒	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way?	☐	☒	☐	☐

FOR OFFICE CODING: Maj Dep Syn if #2a or b and five or more of #2a-i are at least —More than half the days (count #2i if present at all) . Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least —More than half the days (count #2i if present at all).

Major Depressive Disorder Diagnosis. The criteria for Major Depressive Syndrome are met since she checked #2a "nearly every day" and five of items #2a to i were checked "more than half the days" or "nearly every day". Note that #2i, suicidal ideation, is counted whenever it is present.

In this case, the diagnosis of Major Depressive Disorder (not Syndrome) was made since questioning by the physician indicated no history of a manic episode; no evidence that a physical disorder, medication, or other drug caused the depression; and no indication that the depressive symptoms were normal bereavement. Questioning about the suicidal ideation indicated no significant suicidal potential.

PHQ-9 Depression Severity. This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of “not at all,” “several days,” “more than half the days,” and “nearly every day,” respectively. PHQ-9 total score for the nine items ranges from 0 to 27. In the above case, the PHQ- 9 depression severity score is 16 (3 items scored 1, 2 items scored 2, and 3 items scored 3). Scores of 5, 10, 15, and 20 represent cut points for mild, moderate, moderately severe and severe depression, respectively. Sensitivity to change has also been confirmed.

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USE OF SOME SCREENERS AS SEVERITY AND OUTCOME MEASURES

PHQ-9 Depression Severity. This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of “not at all,” “several days,” ”more than half the days,” and “nearly every day,” respectively. PHQ-9 total score for the nine items ranges from 0 to 27. In the above case (see table 3, page 5), the PHQ-9 depression severity score is 16 (3 items scored 1, 2 items scored 2, and 3 items scored 3). Scores of 5, 10, 15, and 20 represent cutpoints for mild, moderate, moderately severe and severe depression, respectively. Sensitivity to change has also been confirmed. The PHQ-8 is scored just like the PHQ-9 and its total score ranges from 0 to 24. Cut points on the PHQ-8 are identical to the PHQ-9.

GAD-7 Anxiety Severity. This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of “not at all,” ”several days,” “more than half the days,” and “nearly every day,” respectively. GAD-7 total score for the seven items ranges from 0 to 21. Scores of 5, 10, and 15 represent cut points for mild, moderate, and severe anxiety, respectively. Though designed primarily as a screening and severity measure for generalized anxiety disorder, the GAD-7 also has moderately good operating characteristics for three other common anxiety disorders – panic disorder, social anxiety disorder, and post-traumatic stress disorder. When screening for anxiety disorders, a recommended cut point for further evaluation is a score of 10 or greater.

PHQ-2 and GAD-2 Severity. These consist of the first two items of the PHQ-9 and GAD-7 respectively, and constitute the two core DSM-IV items for major depressive disorder and generalized anxiety disorder, respectively. Each ranges from a score of 0 to 6. The operating characteristics of these ultra-brief measures are quite good; the recommended cut points for each when used as screeners is a score of 3 or greater. When used together, they are referred to as the PHQ-4 a 4-item screening measure which ranges from a score of 0 to 12, and serves as a good measure of “caseness” (i.e., the higher the score, the more likely there is an underlying depressive or anxiety disorder). In particular, the PHQ-2 and GAD-2 subscores of the PHQ-4 provide separate depressive and anxiety scores, and can be used as screeners for depression and anxiety.

PHQ-15 Somatic Symptom Severity. This is calculated by assigning scores of 0, 1, and 2 to the response categories of —not at all, bothered a little, and “bothered a lot”, for the 13 somatic symptoms of the PHQ (items 1a-1m). Also, 2 items from the depression module (sleep and tired) are scored 0 (not at all), 1 (several days) or 2 (more than half the days or nearly every day). Thus, a PHQ-15 score can be derived from page 1 of the PHQ, or from separate administration of the PHQ-15 scale or the PHQ-SADS. PHQ-15 scores of 5, 10, and 15 represent cut points for low, medium, and high somatic symptom severity, respectively.

Sensitivity to Change for Monitoring Treatment Outcomes. A particularly important use of a measure is its responsiveness to changes of condition severity over time. This is well- established for the PHQ-9 which is increasingly used as a measure to assess the level of depression severity (for initial treatment decisions) as well as an outcome tool (to determine treatment response).[6,10] An example of how different PHQ-9 severity levels might guide treatment is shown in Table 4, page 7. There is preliminary evidence that the PHQ-15 may be responsive to changes as individuals with somatoform disorders or high somatization are treated.[10] The GAD-7 has demonstrated change as a secondary anxiety outcome in several depression trials, but has not yet been studied as a primary outcome in anxiety trials. Also, since there is more diagnostic splitting for anxiety than for depressive disorders, it remains to be determined whether a single anxiety measure can suffice as an outcome measure. It is likely the GAD-7 will be useful but not yet certain it will be sufficient.

Psychometrics. The psychometrics of the PHQ and its component scales are described in the validation articles for specific measures (see Selected References on page 9) and are summarized in a review article on the PHQ-9, GAD-7, and PHQ-15.[10]

Table 4. PHQ-9 Scores and Proposed Treatment Actions *

PHQ-9 Score	Depression Severity	Proposed Treatment Actions
0 – 4	None-minimal	None
5 – 9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10 – 14	Moderate	Treatment plan, considering counseling, follow-up and/or pharmacotherapy
15 – 19	Moderately Severe	Active treatment with pharmacotherapy and/or psychotherapy
20 – 27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

*** From Kroenke K, Spitzer RL, Psychiatric Annals 2002;32:509-521**

TRANSLATIONS

There are numerous translations of the PHQ as well as the PHQ-9 and GAD-7 available in many languages, which are freely downloadable on the PHQ website (www.phqscreeners.com). The abbreviated versions of these measures – PHQ-8, PHQ-2, GAD-2, and PHQ-4 – can simply be derived from the translations by selecting the relevant items (see Table 1, page 3). The PHQ-15 can also be simply derived by selecting the 13 somatic items (1a-1m), plus the *sleep* and *tired* items (2c and 2c) from the PHQ translations.

Many of the translations have been developed by the MAPI Research Institute using an internationally accepted translation methodology. Thus, most of the translations are linguistically valid. However, unlike the English versions of the PHQ and GAD-7, few of the translations have been psychometrically validated against an independent structured psychiatric interview.

If a translation is not available for a language you are interested in using, and you have the interest and resources to develop a linguistically valid translation, please send an e-mail to questions@phqscreeners.com for instructions on how to proceed. One requirement is that we are provided a copy of the final translation as well as a description of the translation methodology.

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WEBSITE

Copies of the PHQ family of measures, including the GAD-7, are available at the website: www.phqscreeners.com

Also, translations, a bibliography, an instruction manual, and other information is provided on this website.

QUESTIONS NOT ADDRESSED IN THIS INSTRUCTION DOCUMENT

For further questions, please send an e-mail to questions@phqscreeners.com

QUESTIONS REGARDING DEVELOPMENT, ACKNOWLEDGMENTS AND USE

The PHQ family of measures (see Table 1, page 3), including abbreviated and alternative versions as well as the GAD-7, were developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

All of the measures included in Table 1 are in the public domain. No permission is required to reproduce, translate, display or distribute.

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Center for Epidemiologic Studies Depression Scale (CES-D Scale)

Patient Name:_____ **Date:** _____

Instructions: Please read each question carefully, then **circle** one of the numbers to the right to indicate how you have felt or behaved **during the past week,** including today.

	RARELY OR NONE OF THE TIME (LESS THAN 1 DAY)	SOME OR A LITTLE OF THE TIME (1–2 DAYS)	OCCASIONALLY OR A MODERATE AMOUNT OF TIME (3–4 DAYS)	MOST OR ALL OF THE TIME (5–7 DAYS)
1. I was bothered by things that usually don't bother me.	0	1	2	3
2. I did not feel like eating; my appetite was poor.	0	1	2	3
3. I felt that I could not shake off the blues even with help from my family or friends.	0	1	2	3
4. I felt that I was just as good as other people.	0	1	2	3
5. I had trouble keeping my mind on what I was doing.	0	1	2	3
6. I felt depressed.	0	1	2	3
7. I felt that everything I did was an effort.	0	1	2	3
8. I felt hopeful about the future.	0	1	2	3
9. I thought my life had been a failure.	0	1	2	3
10. I felt fearful.	0	1	2	3
11. My sleep was restless.	0	1	2	3
12. I was happy.	0	1	2	3
13. I talked less than usual.	0	1	2	3
14. I felt lonely.	0	1	2	3
15. People were unfriendly.	0	1	2	3
16. I enjoyed life.	0	1	2	3
17. I had crying spells.	0	1	2	3
18. I felt sad.	0	1	2	3
19. I felt that people dislike me.	0	1	2	3
20. I could not get "going."	0	1	2	3

Pain Assessment Tools

6/22/2016 pain.jpg (640×456)

UNIVERSAL PAIN ASSESSMENT TOOL

This pain assessment tool is intended to help patient care providers assess pain according to individual patient needs. Explain and use 0-10 Scale for patient self-assessment. Use the faces or behavioral observations to interpret expressed pain when patient cannot communicate his/her pain intensity.

Verbal Descriptor Scale	NO PAIN	MILD PAIN	MODERATE PAIN	SEVERE PAIN	VERY SEVERE PAIN	WORST POSSIBLE PAIN
WONG-BAKER FACIAL GRIMACE SCALE						
ACTIVITY TOLERANCE SCALE	NO PAIN	CAN BE IGNORED	INTERFERES WITH TASK!	INTERFERES WITH CONCENTRATION	INTERFERES WITH BASIC NEEDS	BEDREST REQUIRED
SPANISH	NADA DE DOLOR	UN POQUITO DE DOLOR	UN DOLOR LEVE	DOLOR FUERTE	DOLOR DEMASIADO FUERTE	UN DOLOR INSOPORTABLE
ARMENIAN	Ոչմի ցավ	Թեթև ցավ	Միջին ցավ	Շատ ցավ	Շատ-շատ ցավ	Անտանելի ցավ
KOREAN	통증 없음	가벼운 통증	견딜수 있을 만큼의 통증	심한 통증	아주 심한 통증	극심한 통증
TAGALOG	HINDI MASAKIT	KAUNTIG SAKIT	MEDYO MASAKIT	TALAGANG MASAKIT	MASAKIT NA MASAKIT	PINAKAMASAKIT

Form 1.1 Initial Pain Assessment Tool

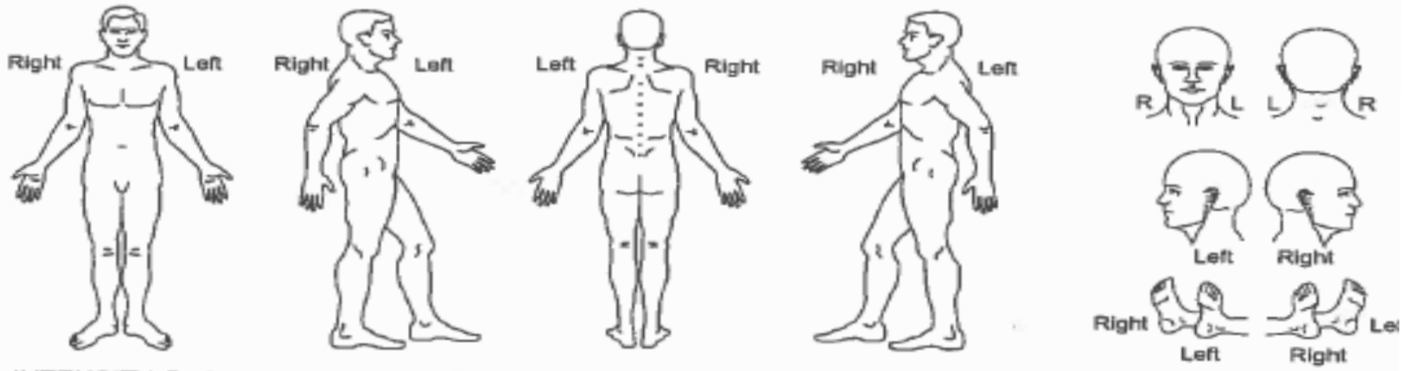
Date _____

Patient's Name _____ Age _____ Room _____

Diagnosis _____ Physician _____

Nurse _____

1. LOCATION: Patient or nurse mark drawing.



2. INTENSITY: Patient rates the pain. Scale used _____

Present pain: _____ Worst pain gets: _____ Best pain gets: _____ Acceptable level of pain: _____

3. IS THIS PAIN CONSTANT? _____ YES; _____ NO IF NOT, HOW OFTEN DOES IT OCCUR? _____

4. QUALITY: (For example: ache, deep, sharp, hot, cold, like sensitive skin, sharp, itchy) _____

5. ONSET, DURATION, VARIATIONS, RHYTHMS: _____

6. MANNER OF EXPRESSING PAIN: _____

7. WHAT RELIEVES PAIN? _____

8. WHAT CAUSES OR INCREASES THE PAIN? _____

9. EFFECTS OF PAIN: (Note decreased function, decreased quality of life.)

Accompanying symptoms (e.g., nausea) _____

Sleep _____

Appetite _____

Physical activity _____

Relationship with others (e.g., irritability) _____

Emotions (e.g., anger, suicidal, crying) _____

Concentration _____

Other _____

10. OTHER COMMENTS: _____

11. PLAN: _____

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Brief Pain Inventory (Short Form)

Study ID# _____ Hospital# _____

Do not write above this line

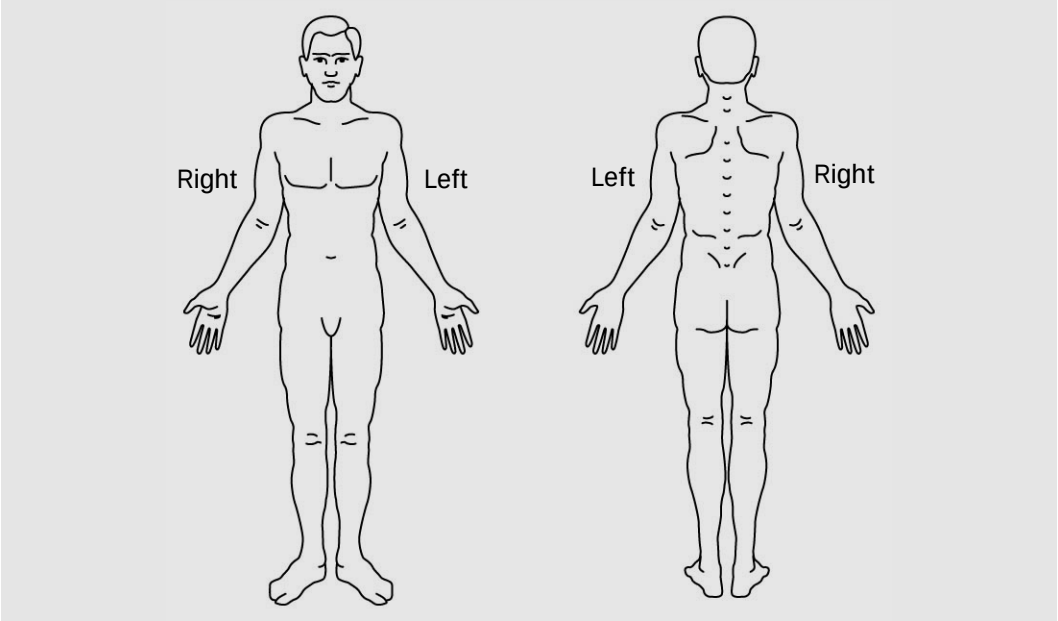
Date: _____ Time: _____

Name: _____ Last
First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

8) In the past 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much RELIEF you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No relief										Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

B. Mood:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completey interferes

C. Walking ability:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

D. Normal work (includes both work outside the home and housework):

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

E. Relations with other people:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

F. Sleep:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

G. Enjoyment of life:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

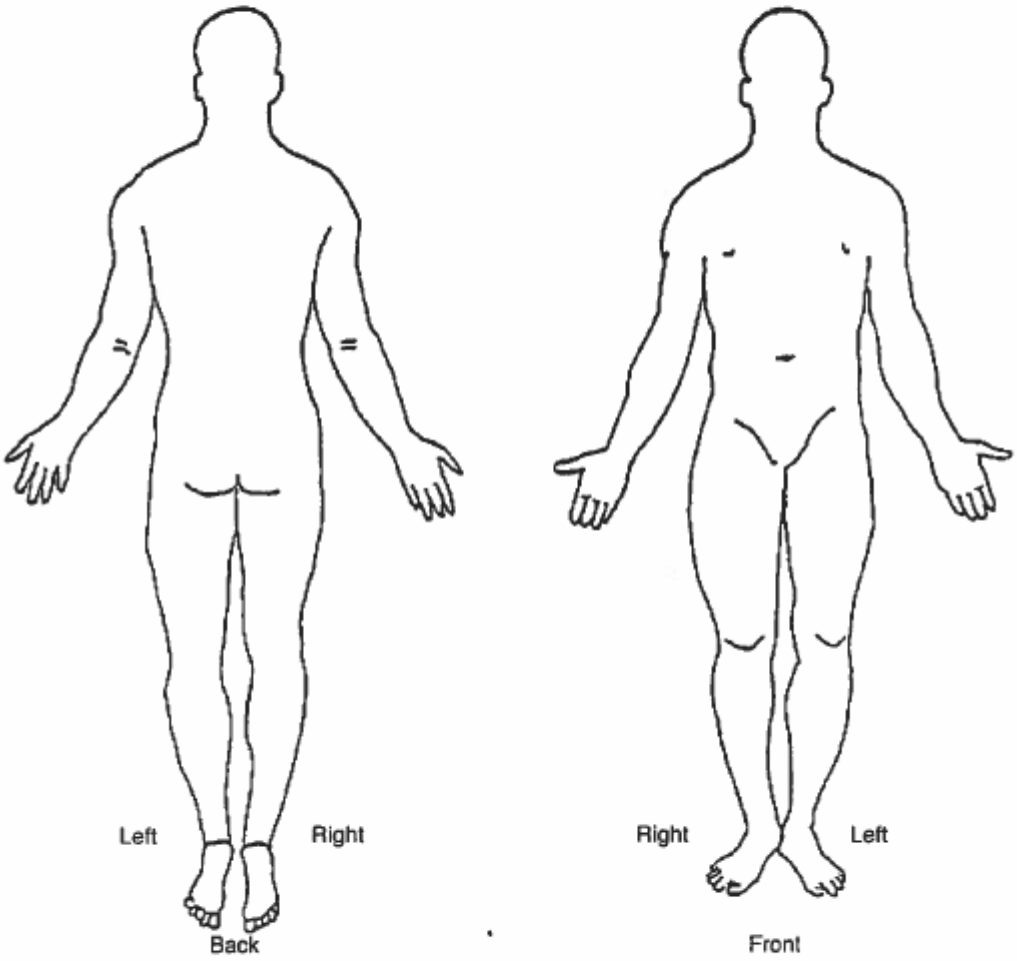
Reference: Brief Pain Inventory. Charles Cleeland, PhD. Pain Research Group. Copyright 1991. Used with permission.

PATIENT PAIN DRAWING

Name _____ Date _____

Where is your pain now?
Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.
Mark the areas of radiation. Include all affected areas.

ACHING	NUMBNESS	PINS AND NEEDLES	BURNING	STABBING
▲▲▲	≈≈≈	ooo	xxx	///



PLEASE MARK ON THE LINE:

How bad is your pain now?

❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿

NO PAIN — **INTERMEDIATE PAIN** — **WORST PAIN**

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Medical Billing Dispute Resolution

The Division's Medical Policy Unit facilitates disputes involving compliance with the Workers' Compensation Rules of Procedure 16 (Utilization Standards) and 18 (Medical Fee Schedule.) Rule 16-11(E) outlines the dispute resolution process.

Most common disputes:

1) **Billing disputes and disputes involving future medical treatment**
   - Untimely bills: (Rule 16-7(F)) states providers must submit bills within 120 days of service
   - Non- payment: Rule 16-11(A)(3) states bills are due and payable within 30 days.
   - Disagreements on application of contract discounts.
   - Providers balance-billing claimants for medical treatment associated with admitted claims
     51)
2) **Prior authorization**
   - Provider not explaining the reasonableness or the medical necessity of the services requested or not providing relevant supporting documentation
   - Payer not timely responding to a complete request for prior authorization (within 7 business days)
   - Payer not appropriately applying Medical Treatment Guidelines.

Dispute Resolution Process/Steps

Step 1: Party requests dispute resolution
- Requesting party should follow Rule 16-11(D)) for contesting billed services or Rules 16-9 and 16-10 for the prior authorization process
- Requesting party must complete Form WC181 and attach all relevant documents
- Requesting party should keep copies of all relevant communication and correspondence from the other party and attach them to the WC181 form.

Step 2: Division's Medical Policy Unit (MPU) Receives and reviews submission
- If criteria has been met, and the MPU determines there is good cause for facilitating a dispute, a written request for the other party will be sent and they must respond in 10 business days.
- If dispute resolution criteria have *not* been met the MPU will issue an explanation.
- The MPU will review merits of the dispute within 30 days of receiving documentation from both parties.

Step 3: Division's MPU Course of Action
- If no violation found, the MPU will facilitate a resolution to the best of its ability. If no agreement can be reached, the file will be closed with information provided and available through the Office of Administrative Courts (OAC)
- If parties come to an agreement, the MPU will close the file
- If the Director finds a violation of Rules 16 or 18, the Director will issue an order citing the violation and considering penalties.

Step 4: Remedies

- Section 8-47-101(2), C.R.S. states that the Director and the Division shall enforce the Workers' Compensation Act of Colorado.
- Order to comply with the Rules (i.e.: pay the disputed bill.)
- Prior authorization request is deemed authorized for payment, per Rule 16-10(E)
- Impose penalties up to $1000 per day per each offense until a responding party complies
  - Penalties may be imposed for an act or a failure to act in a reasonable way to comply with lawful order (i.e.: failure to comply with a Division rule)
  - Penalty factors include: pattern and duration of non-compliance, degree of reprehensibility (whether conduct is willful or an explanation/mitigating factors), harm to aggrieved party
- Apportionment of Penalties:
  - Money penalties are apportioned between the aggrieved party and the workers' compensation cash fund
  - Amount apportioned to the aggrieved party must be at least 50% of penalties assessed

Appeals

According to § 8-42-301 (2), C.R.S., any party dissatisfied with a Director's order that requires any party to pay a penalty or benefits or denies a claimant any benefit or penalty may file a petition to review with the Division within 20 days. The Director may either issue a supplemental order or send the matter to the Industrial Claim Appeals Office (ICAO) for review.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation
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Phone: (303) 318-8700 | Fax: (303) 318-8758
cdle_medicalpolicy@state.co.us

MEDICAL DISPUTE RESOLUTION INTAKE FORM

Name of Contacting Party: _____
Title: _____
Mailing Address: _____
Email Address: _____
Phone: ( ) _____ Fax: ( ) _____

Provider/Payer Initiating Dispute: _____
NPI or Tax ID#: _____
Other Party Involved in Dispute: _____

Claimant: _____ Date(s) of Service: _____
Employer: _____ Date(s) of Injury: _____

Disputed amount:

- Payment you received: $ _____
- Payment you believe you should have received: $ _____
- Explain how you arrived at this amount:

_____

Have you followed the procedures in Rule 16-12(D)? ☐ Yes ☐ No
If not, why? _____

Issue(s) in Dispute (check all that apply):

☐ Rule _____ ☐ UCR
☐ CPT® ☐ Supply
☐ PPO Contract ☐ Other _____

Briefly explain the dispute:

_____
_____
_____

What actions have you taken to resolve this dispute? *(Include person(s) you spoke with and date(s) if available)*

_____
_____

Please attach all applicable supporting documents:

☐ Original bill
☐ EOB(s)/EOR(s)
☐ Prior authorization
☐ Invoice(s)
☐ Appeal(s)
☐ Office/procedure/operation notes
☐ Call logs/emails
☐ Correspondence from other party
☐ Copy of request for contract

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DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation
7 CCR 1101-3
WORKERS' COMPENSATION RULES OF PROCEDURE

Rule 13 Provider Accreditation

13-1 STATEMENT OF BASIS AND PURPOSE

(A) This rule implements and establishes procedures for the provider accreditation program set forth in § 8-42-101(3.5) and (3.6), C.R.S., as well educates the providers about their administrative, legal, and medical roles in the Colorado workers' compensation system. Accreditation requirements shall apply to:

(1) Providers who seek Level I or Level II accreditation under § 8-42-101(3.5) and (3.6), C.R.S.;

(2) Physicians providing permanent impairment evaluations of claimants; and

(3) Physicians serving on the Division Independent Medical Examination Panel.

13-2 ACCREDITATION

(A) To obtain Level I Accreditation, a provider must:

(1) Qualify under § 8-42-101(3.5), C.R.S.**;**

(2) Complete an application form prescribed by the Division and pay the registration fee;

(3) Complete the Division Level I course;

(4) Demonstrate an understanding of the Division materials by passing a Division-administered examination. If the provider does not exhibit sufficient knowledge upon taking the examination a second time, he or she must attend the seminar again prior to any further attempts at the examination. Additional fees may apply.

(5) Agree to comply with all relevant statutes, Division rules, and all Division-issued guidance (including materials incorporated by reference);

(6) The accreditation begins on the date the provider passes the examination. The accreditation expires on July 31st of the third year following the year the provider passed the examination**.**

(B) To obtain Level II Accreditation, a physician must:

(1) Receive Level I accreditation. However, a physician who received his/her initial Level II accreditation before January 1, 2018 is exempt from this requirement.

(2) Qualify under § 8-42-101(3.5), C.R.S.;

(3) Complete an application form prescribed by the Division, pay the registration fee, and indicate if full or limited accreditation is sought;

(4) Complete the Division Level II course;

(5) Demonstrate an understanding of the Division materials (including the American Medical Association Guides to the Evaluation of Permanent Impairment, as incorporated by reference into § 8-42-101(3)(a)(I), C.R.S. ('AMA Guides')) by passing a Division-administered examination. If the provider does not exhibit sufficient knowledge upon taking the examination a second time, he or she must attend the seminar again prior to any further attempts at the examination. Additional fees may apply.

(i) Full Accreditation: A physician who passes the full Level II Accreditation examination shall be fully accredited to determine permanent impairment ratings on any work-related injury or illness.

(ii) Limited Accreditation: A physician who seeks Level II Accreditation to rate impairment only in connection with a specialty medical practice and who satisfactorily completes specified portions of the Level II examination shall receive limited accreditation to determine permanent impairment ratings on the corresponding sections of the AMA Guides.

(6) Agree to comply with all relevant statutes, Division rules, and all Division-issued guidance (including materials incorporated by reference).

(7) Submit his/her first three (3) impairment rating reports deemed sufficient by the Division within 12 months of passing the Level II accreditation examination; and

(8) Agree to the probationary one-year Level II accreditation period beginning on the date the physician passes the Level II accreditation examination. The probationary accreditation will expire if the physician fails to submit three (3) impairment rating reports deemed sufficient by the Division within one year of the examination. Non-probationary accreditation begins on the date the physician submits his/her first three (3) impairment rating reports deemed sufficient by the Division. The non-probationary accreditation expires on January 31ST of the third calendar year following the year the physician successfully completed the Level II Accreditation examination.

13-3 RENEWAL OF ACCREDITATION

(A) The Division will attempt to notify accredited providers of impending expiration of their accreditation.

(B) A provider who does not renew his or her accreditation before the expiration date may reapply and complete the process for initial accreditation under section 13-2.

(C) To renew accreditation, a provider must:

(1) Qualify under § 8-42-101(3.5), C.R.S.;

(2) Complete an application form prescribed by the Division, pay the registration fee, and, for Level II accreditation, indicate if full or limited reaccreditation is sought;

(3) Complete the Division course requirements for the highest level of accreditation maintained;

(4) Agree to comply with all relevant statutes and Division rules; and

(5) For Level II reaccreditation only, submit one impairment rating report deemed sufficient by the Division (which may be a Division Independent Medical Examination report) for audit. The purpose of providing an impairment report is to demonstrate an understanding of the requirements of a sufficient impairment rating report; to educate and provide feedback to the physician; and to assist the Division in examining its curriculum. Any correspondence or communication regarding this process is confidential and shall not be subject to discovery or examination by any person.

13-4 SANCTIONS UPON ACCREDITATION

(A) The Director, with input from the Medical Director, may initiate proceedings to sanction a Level I or Level II Accreditation on any of the following grounds:

(1) Refusal to comply, substantial failure to comply, or two or more incidents of failure to comply with the provisions of these Workers' Compensation Rules of Procedure and all relevant statutes.

(2) Misrepresentation on the application for accreditation, or

(3) A unanimous recommendation to revoke accreditation by a reviewing panel pursuant to § 8-43-501(3)(c)(III) and (4), C.R.S..

(B) The severity of any sanctions taken under these rules shall reflect the character of the failure and the attendant circumstances. Examples of sanctions include, but are not limited to, a suspension or a revocation of accreditation.

(C) A proceeding to sanction a Level I or Level II Accreditation may be initiated by the Director, with input from the Medical Director, with referral for a hearing before an administrative law judge.

(D) Following a hearing, the administrative law judge shall render proposed findings of fact and conclusions of law, and make recommendations to the Director, who shall enter an order in the case.