

ALL ABOUT CLAIMS



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All About Claims is a newsletter published by the Colorado Division of Workers' Compensation designed to provide information to claims practitioners. Please send comments or suggestions for future topics to Adam Gardner by emailing adam.gardner@state.co.us.

DIVISION LAUNCHES CLAIMS COMPUTER SYSTEM

Colorado's Division of Workers' Compensation has taken a big step in shaking up its antiquated legacy computer system, the one that is used to track all workers' compensation claims filings.

The new system tracks all workers' compensation claims filings for injured workers. It is a critical resource used to oversee the claims handling process, monitoring the chronology of events and ensuring coverage and proper payments. The Division wanted to retain the best of the legacy system's features while building important new features.

To do that, the Division contracted with innoWake International, Inc., a San Francisco-based software company that specializes in modernizing legacy applications. The company created a new system that is simple and transparent. However, beneath the user-friendly interface is a complexity that is formidable. It is vastly superior to (and much cheaper than) the patchwork of fixes that plague most legacy systems.

What was built is a cloud-based application, capable of being accessed through the internet from any location with increased capacity and enhanced functionality. And, perhaps most importantly, the new system offers something called "future scalability," that is, the ability of the computer network to grow as the business needs change. Not taking scalability into account can mean spending more money on an infrastructure that isn't responsive to business needs down the road.

Already, the system's agility and flexibility are allowing staff to start thinking of ways to customize the system to better address current and future needs. Anticipated efficiencies include the creation of fly-out and drop-down menus as well as more sophisticated search functions that will enable staff to pull information from other screens at a glance.

Work on the new computer system began several years ago in the best tradition of Silicon Valley with Division staff rolling out the new product in stages, testing it, improving it and repeating the process for continuous improvement. By mid-2015 a few testers were entering data into the newly created database.

A "bridge" was constructed, allowing data to be shuttled back and forth between the legacy database and the new database. This cautious approach ensured system stability prior to disabling the data bridge and launching the new system.

Then, a few weeks ago with the Division's Technical Operations Unit standing by, innoWake shut down the data bridge and the new full conversion was launched. The entire database and all corresponding programs were migrated and converted successfully on that day.



When a tech team succeeds with a project like this, the general public likely won't think much about it. "When a government program works efficiently and can grow with new software and design concepts, it might not be big news," says Department of Labor and Employment Executive Director Ellen Golombek, "but our staff has done a remarkable job. We're proud of what's been created and the ease with which it was rolled out. It makes for a more user-friendly government, a more responsive government, one that will continue to improve in the years ahead."

Division Says *Good-Bye* to Longtime Medical Program Manager



Becky Greben, who managed both the Division Independent Medical Examiner (DIME) and Physician Accreditation Programs, has decided to retire from public service and further cultivate some much-loved activities. As a strong advocate for the system, Becky devoted herself to ensuring physicians had the necessary information and tools to function effectively in an environment that was often adversarial. She did it with real energy and tenacity. We asked her to talk about the evolution of the programs and provide some thoughts for the future.

1. Tell us a little about yourself.

I was born and raised in Chicago (city-proper) but I've lived in Denver since 1980. I obtained a Bachelor's in psychology from the University of Wisconsin-Whitewater but after moving here I decided to get a second degree in geology. So now I refer to my credentials as BS-squared. Really, what better place to learn about geology than Colorado? I never really intended to work in

that field but I have always had an interest in science. This mainly supports my long-time personal interest in paleontology. I was one of those kids who read books about dinosaurs and never really grew out of it.

I have volunteered with the Denver Museum of Nature & Science for about 20 years now, as a preparator in the fossil lab. Currently my project is a rather large – 50-million year-old fish, which has about a thousand tiny bones and an exploded head. I've also been involved for about 25 years with the Western Interior Paleontological Society. Regarding other interests, I also work with some non-profit advocacy groups that I plan to do more with after I finish up here. I also love to travel.

Right after getting my psychology degree, I worked for 3 – 4 years in a group home for disturbed or homeless adolescents in the Chicago area. In 1977 I received a graduate-level certificate in paralegal studies, back when there were very few programs of that nature and the course was designed to be like the first year of law school crammed into 4-1/2 months. Happily I got a job right away with a major law firm in Chicago and then continued with that work after moving to Denver. I also worked for Westlaw for about 4 years as a trainer. My paralegal experience is how I got my foot in the door at the Division.

I like to keep up on current events in the old-fashioned way of –gasp!—reading a real newspaper every day, although lately I've been getting a little behind. My parents were political and social activists, so this interest kind of comes naturally. I think that unfortunately the rise of the Internet as the “infotainment superhighway” is leading to the demise of effective and literate journalism. There are probably only five or six really good newspapers left in the U.S. Fortunately there are some decent magazines and journals still around, both in hard-copy and online.

2. Did you ever imagine you'd have a career in worker's compensation?

Not really! In late 1993 I was looking for another job, and a friend of mine who worked here at that time told me there were some openings. Earlier I had worked for about 4 years with a personal injury lawyer so I had some knowledge of the general area of law, but I didn't know much about work comp. specifically. I succeeded in getting a position as the Utilization Review program coordinator, which then was a much busier program. At that time I saw it as just another job but one that might have some growth potential, so I stuck around and am glad I did. I've now been here with CDLE for 22 years. This included a couple of years as the Public Employee Social Security (PESS) program coordinator, which at that time was part of the department's finance office. I re-joined the DOWC as a manager in early 2000.

3. What was the environment like when you came to work at the Division?

I started in January 1994 which was just a few years out from the implementation of Senate Bill 218, which created the Division as we know it today. I think the number of employees was a little higher than it is today, but the programs were staffed differently. Learning processes were still in progress at many levels, and so the dynamics within and between the Division and its stakeholders were different. Some programs were still not fully developed. For example, some of the medical treatment guidelines as well as some of our formal rules were still in their initial draft stages, and there are people still around today, both in and outside of the Division, who were involved in that developmental work. With all its newness, there was certainly a different type of energy. It was a positive energy, but everyone involved the system was to some extent still sort of feeling their way around.

4. How has the Division Independent Medical Exam (DIME) program evolved?

It has not changed in terms of its role in the system, but certainly its implementation has changed significantly due to both statutory and regulatory revisions in the last 20+ years. Probably most significantly was the creation of section 8-42-107.2 in the late 1990's – this was when I was working for the PESS program – where the DIME program truly got its own statutory section. Clearly it needed a better-defined structure that was apparently best addressed by legislation, and as we know that section has been further amended since that time. Many rule changes, also. Although there is a better-defined structure, all the add-ons have also created more complexity for the involved parties, the physicians, and the Division staff. This can be problematic. The DIME program has over time developed many administrative quirks, and in my view that's because the regs and the statute have evolved in kind of a whack-a-mole process. "Oh, here's a problem; let's see if we can fix it in the rule." Or in the statute. Then some unintended consequence comes up that further needs to be addressed. This is partly what keeps the Prehearings Unit busy.

“One of the more interesting changes is that in the early days of the program the requesting party was overwhelmingly the respondent. Within 4 or 5 years that trend turned toward the claimant, and it has remained there ever since.”

On another topic the consensus is that DIME cases have become more complex over time. In recent years there appears to have been a push to try to settle the medically-simpler cases, so we don't see as

many of those anymore. One of the more interesting changes is that in the early days of the program the requesting party was overwhelmingly the respondent. Within 4 or 5 years that trend turned toward the claimant, and it has remained there ever since. Claimants now request about 80 – 85% of all DIMEs. At various times in the past I have researched similar programs used in other states, but none of them have this kind proportion. In fact it's usually the opposite, but our program's statutory mandate is rather unique. I have the sense that for most claimants the main issue is MMI, but because of how the DIME application is completed I can't really confirm this with data. Obviously the respondent would be disputing impairment.

One thing that maybe has not changed much is the ongoing need for more physicians to join the panel, especially outside of the Front Range area. It can be a challenging program for physicians on many fronts: the time investment, the financial reimbursement vs. the amount of work often performed, the potential for litigation, etc. Some years back we performed an informal telephone survey of some DIME doctors, asking for what reasons they continued to be involved in the program. Most of them understood that in this work they were essentially performing a public service, but they also cited reasons such as being able to see interesting or medically challenging cases, and keeping up on what's going on in the local occupational medicine community. The DIME unit now has an internal program where each DIME staff serves as a kind of "go-to" person for specific DIME doctors, to educate and assist them administratively with the demands of the program. It's a great service for those doctors. However, from day one there have been difficult issues between the parties and the doctors, and in many cases a lot of blame to spread around. That hasn't changed. In the last couple of years the Division's new Medical Dispute Resolution program has been able to help with some of the disputes involving payment.

5. How has Physicians Accreditation's landscape changed since you've been here?

Not near as much as the DIME program has changed. The basis for the impairment rating system, the AMA Guides 3rd edition revised, is in statute and therefore we're still using a book that was written in 1990, much to the dismay of most of the docs, I might add. Therefore, especially for Level II, the teaching of the methodology hasn't changed much. Same thing for Level I which has traditionally been oriented to chiropractors, but that is undergoing some modification at this time. The statute requires that for accreditation we must instruct the providers as to their legal and medical roles in the system, and those roles haven't substantially changed. One challenge is that the number of docs being board-certified specifically in occupational medicine has been in decline, and in general we have had ongoing attrition in the total numbers of accredited physicians, especially in Level I. And this is as Colorado's population has been increasing. How much has this impacted our system? We could probably have a long discussion on that as every constituent of the system, including the Division and physicians, would have different but valid points of view.



Up until about 2 years ago the Physicians' Accred. program operated with a very small staff and other limited resources. This made it logistically difficult to focus on new directions or increase the scope of some of what we are authorized to do. About 2 years ago that changed as we were able to add more staff and therefore look at expanding some of our educational endeavors. More specifically, we are treating Level I accreditation not only as a the means



for the statutorily-approved providers to get credentialed, but we are opening it up to auditing by many other types of health care providers, especially physician assistants, nurse practitioners, physical and occupational therapists, and psychologists. These types of specialists are increasingly more visible and important in health care in general, and Level I provides formal instruction on how the workers' comp. system works, its quirks, and provider's duties and obligations when providing care to injured workers. They cannot be officially accredited, but we recently have added to our website a list of those who have completed this Division training for reference by any other user of our website. We also want to actively encourage medical doctors who do not want to do impairment ratings yet treat injured workers to take the Level I course as it's probably the most efficient and effective way for them to learn about the workers' comp. system. So, our Level I program has evolved quite significantly in recent years, and that will likely continue for a while.

6. How did you help these programs get to where they are now?

I think it has always been important to maintain program stability and maintain a predictable level of good service. That predictability improves credibility. Of course at times things have not gone as well as we would have liked, but we try to learn from mistakes and not repeat them. The DIME program has long been a battleground, but

we've managed to largely succeed in its legislative intent to resolve most but certainly not all medical disputes, and reduce litigation. Some people reading this may not agree, but in fact this is what the numbers show.

For the IME program there have been multiple changes in processes and formal procedures over the years that have affected all users of that program, including the doctors and the DIME unit staff. Rule and statute revisions have required many changes to our internal procedures, and, as a manager I had to oversee the drafting and implementation of those process changes. One of my priorities was to ensure that all of those affected received proper notice and instruction on those new procedures, and I would like to think that most of the time the transitions—at least internally where I had some control – went fairly smoothly. So most of the procedural changes and adjustments to the program in the last 14 – 15 years went forward under my management, and with implementation by a very experienced and capable staff, things usually went pretty well.

For Physicians' Accreditation, most of the time the objective was just maintaining stability and keeping things working as well as possible given the limited staff available. In fact for years there was only one staff exclusively devoted full-time to the program, our very knowledgeable administrative assistant, Kay Bothwell. However, as I noted earlier we now have more staff dedicated to Physicians' Accreditation, and that

occurred a couple years ago when I (rather prematurely) announced my retirement, but then decided to stick around for a while as a program specialist. This opened up an opportunity to consider a new staffing pattern. The program management and other duties have been allocated to some new but very innovative and hard-working staff, Kari Gomes and Gina Johannesman, plus a few who have been here a little longer such as managers Dan Sung and Christy Hunter-Culkin. They are pursuing fresh ideas about ways to update the program while still maintaining our statutory educational mandate. The last couple of years have been kind of fun with this new focus.

7. In your opinion, will the programs remain static or will there likely be changes to these programs in the future? What are the drivers, if any, of change?

Well, some of my answers to the previous questions covered much of this. We're already internally doing an intensive DIME rule review—that would be Rule 11 – to try to identify what can and/or should be addressed, at least in the near term. In the longer term I would like to see a kind of re-boot of the DIME program overall, with some thinking-outside-the-box options. We'll see whether that happens. In my view the driver for change is the need to stop applying patches to the program, because eventually we'll reach some kind of critical mass where it all becomes unwieldy. We should go back and try to find that balance between what's needed on the Division-side for enforcement, versus how the parties can drive the process efficiently, yet minimizing opportunities for disputes. And through this all, maintain an adequate panel of physicians.

With regard to Accreditation, I don't know that we'll see too much change in Level II unless there is a change to the impairment rating system. Perhaps some changes in how it's taught, but the content – not so much. So the biggest driver for change, at least

for now, would involve going to a new AMA Guides edition, but that's in the hands of the legislature. I've already discussed some of the innovations we are initiating for Level I, which I think is a very positive direction. The biggest driver for change there I believe is the increasing reliance on mid-level and other non-physician medical professionals in our health care systems. Health care has become so much more multi-disciplinary.

8. Ideally, are there changes you would like to see in these programs in the future and if so what barriers would have to be overcome to effect these changes in your opinion?

Again, I think I discussed much of this in the other questions. I would like to add one hope that the accreditation statute can be expanded to include other types of non-physician specialists as candidates for Level I accreditation or some kind of other officially recognized tier. But, that will require legislation.

I think the barriers to change are the typical things you see when dealing with government programs, such as the political and economic environment, and how after a while everyone becomes somewhat entrenched. Even when something starts to exhibit dysfunction there's a tendency to stick with it because it has become comfortable, for better or for worse. There needs to be the will to push through that. However, in general, I'm hopeful because, in the grand scheme of things, we in Colorado have the luxury of the workers' comp. community being rather small and discrete. People can disagree, and yes we still have a bureaucracy, but everyone's voice is more easily acknowledged. When things work well there's still something to be said for "If it ain't broke, don't fix it." But when trying to resolve problems we should learn to let go of, or at least re-think, our dogmas and orthodoxies. One of my favorite quotes is from physicist Richard Feynman: "I would rather have questions that can't be answered than answers that can't be questioned."

Clarification on Rule 16-4(A)(6): The Use of PAs and NPs

Recently, the Division has been asked to “settle disagreements” when it comes to interpreting Rule 16-4(A)(6), Use of Physician Assistants (PAs) and Nurse Practitioners (NPs) in the Colorado Workers’ Compensation Claims. This is a good reminder that sometimes what is clear to the author isn’t always as clear to the reader. This translation table provides both clarification and intent to the latest rule revision. The Division understands nurse practitioners are not required to practice with physician supervision in Colorado, however, requirements in the Colorado Workers’ Compensation Act require the use of physicians, as defined below. The Division has promulgated rules that allow for the delegation of treatment, when it’s within the PA’s and NP’s scope of practice. Please don’t hesitate to contact the Division if you have additional questions.

What the Rule Says	What the Rule Means
(a) All Colorado Workers’ Compensation claims (medical only or lost time claims) shall have an “authorized treating physician” responsible for all services rendered to an injured worker by any PA or NP.	Per C.R.S. 8-42-101(3.5)(a)(1) a “physician” is defined as licensed under the Colorado Medical Practice Act. As per the Act, a person licensed to practice medicine may delegate under their personal and responsible direction, the practice of medicine to a PA or NP.
(b) The authorized treating physician provider must be immediately available in person or by telephone to furnish assistance and/or direction to the PA or NP while services are being provided to an injured worker.	As required by the Colorado Medical Board Rules and Regulations, if not physically on site with the PA (and for the purpose of Rule 16, an NP), the primary or secondary physician supervisor must be readily available by telephone, radio, pager, or other telecommunication device. *
(d) For services performed by an NP or a PA, the authorized treating physician must counter sign patient records related to the injured worker’s inability to work resulting from the claimed work injury or disease, and the injured worker’s ability to return to regular or modified employment. The authorized treating physician also must counter sign Form WC 164. The signature of the physician provider shall serve as a certification that all requirements of this rule have been met.	As per the Colorado Medical Practice Act, the licensed supervising physician reviews the quality of medical services rendered by the PA, by reviewing the medical records to assure compliance with the physician’s directions. The Division requires this be demonstrated by a co-signature, when specified, on the WC 164 form.
(e) The authorized treating physician must evaluate the injured worker within the first three visits to the physician’s office.	If the ATP evaluates the injured worker on the first visit, it’s not necessary to evaluate the injured worker again on the third visit. There is no requirement for re-evaluations by the ATP after this initial evaluation has occurred (i.e., there is no “every third visit” requirement).

*Please note that this portion of rule is separate from the “incident to” criteria incorporated into Rule 18-5(A)(2). The “incident to” criteria allows NPs and PAs in non-rural areas to bill 100% of the Medical Fee Schedule instead of 85%, but requires a higher level of supervision by the authorized treating physician. For more information on “incident to”, please see the Division’s 2016 Interpretive Bulletin at <https://www.colorado.gov/pacific/cdle/user-agreement>.