All About Claims

Colorado Department of Labor and Employment
Division of Workers' Compensation
Claims Services Section, 1515 Arapahoe St., Denver, CO
80202-2117

Roy Romer
Governor

Jon Numair
Executive Director

Mary Ann Whiteside
Director

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All About Claims is a newsletter published by the Claims Services Section of the Colorado Division of Workers' Compensation. It is designed to provide a forum for information exchange among claims handlers working in this area of specialization. We sincerely hope the information is of value and welcome any comments. Comments may be directed to JoAnne Ibarra, Manager of Claims Services, at (303) 575-8816, or by mail at the above Division address.

Reorganization of the Medical Cost Containment Unit
by Mary Ann Whiteside, Director

I am pleased to announce the reorganization of the Medical Cost Containment Unit. This unit has now been split into two units: The Medical Cost Containment Unit and the Medical Services Delivery Unit. The philosophy behind this change is that the separation of functions with fundamentally different purposes into distinct units will assist in differentiating the policy and regulatory roles from the roles of service delivery and compliance. This helps each organizational unit concentrate on achieving one clear purpose. The Medical Cost Containment Unit will provide the policy/regulatory functions, formulating the goals and strategic choices for the cost containment components of the medical programs. The Medical Services Delivery Unit will concentrate on direct medical services and compliance required by statue. The following shows the breakdown of functions in the reorganized structure:

Medical Cost Containment Unit:
- Medical Fee Schedule
- Medical Treatment Guidelines
- Quality Indicators/Assurance

Medical Services Delivery Unit:
- Physicians' Accreditation Program
- Independent Medical Examination
- Utilization Review

Debra Northrup, who has been with the Division since 1990 and is an expert in the Medical Fee Schedule and Treatment Guidelines, is the Medical Cost Containment Unit Manager. I am pleased to announce the appointment of Susan Warren as the Manager of the Medical Services Delivery Unit. Ms. Warren brings an extensive background in legal and medical arenas to the Division. She served in the Attorney General's Office for ten years representing the Health, Social Services, Labor and Employment, Institutions and Personnel Departments. Masters Degree in Public Health at Harvard University. Most recently, she served as the Trauma Program Director for the Department of Public Health and Environment. She then became a policy analyst in the Department of Regulatory Agencies and returned to school in 1994 to get her Masters Degree in Public Health at Harvard University. Most recently, she served as the Trauma Program Director for the Department of Public Health and Environment.

I am excited about these changes and anticipate an increase in efficiency and quality of delivery in the services we provide to all of our customers.

Special Recognition
by Mary Ann Whiteside, Director

It is with regret that I announce the departure of three Division employees: Jim Eldridge, Sharon Elenburg and Paul O'Brian. Jim Eldridge, our Manager of Administrative Operations for over 8 years, is leaving to take a job with Unicom Corporation in Overland Park, Kansas. While at the Division, he represented the state of Colorado in pioneering electronic data interchange (EDI) with the Employers' First Report form. Jim represented the state of Colorado nationally in developing a proof of coverage standard which is a system designed to detect employers who do not have insurance coverage. It was the first of its kind. His move is a real loss both personally and professionally to the organization. Sharon is retiring after more than seventeen years with the Department, serving the Division in many areas including the Independent Medical Examination Program, Hearings Docket and, most recently, the Physicians' Accreditation Program. Sharon has been a caring resource for members of the workers' compensation community. She has had a great enthusiasm for her work and a sense of humor that we appreciated. Paul is returning to private practice in physical therapy after serving the Division for the past two years. His contributions to the development of the Medical Treatment Guidelines and the organization of the Independent Medical Examination Program have been extensive. All of the staff of the Division wish to extend our sincere appreciation to Jim, Sharon and Paul and wish them success in their new adventures.

Amendments to Rules IV and X
By JoAnne Ibarra, Manager, Claims Services

Housekeeping changes to Rules IV and X were adopted in December and are of note to claims handlers. Changes to Rule IV allows an insurance carrier to terminate permanent total

disability benefits without a hearing following the death of the claimant. This tracks the termination provisions found under Rule IX and should create greater efficiencies in the closure of these claims:

K. Admission for Permanent Total Disability Benefits

An insurance carrier shall file an admission of liability for permanent total disability on a final admission of liability form prescribed by the Division.

2. AN INSURANCE CARRIER MAY TERMINATE PERMANENT TOTAL DISABILITY BENEFITS WITHOUT A HEARING BY FILING AN ADMISSION OF LIABILITY FORM WITH ALL OF THE FOLLOWING ATTACHMENTS:

a. A DEATH CERTIFICATE OR WRITTEN NOTICE ADVISING OF THE DEATH OF A CLAIMANT;

b. A RECEIPT OR OTHER PROOF SUBSTANTIATING PAYMENT OF COMPENSATION TO THE CLAIMANT THROUGH THE DATE OF DEATH; AND

c. A STATEMENT BY THE CARRIER AS TO ITS LIABILITY FOR PAYMENT OF:

i. DEATH BENEFITS AND

ii. THE UNPAID PORTION OF PERMANENT TOTAL DISABILITY BENEFITS THE CLAIMANT WOULD HAVE RECEIVED HAD S/HE LIVED UNTIL RECEIVING COMPENSATION AT THE REGULAR RATE FOR A PERIOD OF SIX YEARS.

Changes to Rule X were minor and incorporate overpayment and fraud language which are now included in statute as a basis for reopening an award. The rule further requires that both the Petition to Reopen and response be copied to the opposing party. The rules became effective January 30th.

Notes from Claims Services
By JoAnne Ibarra, Manager, Claims Services

From time to time we get an interesting argument which other claims handlers may find thought provoking. In recent months a question has arisen relative to the application of the caps found at C.R.S. §8-42-107.5. Several Respondents' attorneys have argued that in order to determine which cap applies on a scheduled impairment, the scheduled rating must first be converted to whole person.

For example, if the treating physician assigns a rating of 46% of the lower extremity, the rating is converted to 18% whole person, and the combined temporary and permanent partial disability benefits are capped at $60,000.00 since the rating is 25% or less. The Respondent then admits for the scheduled impairment.

Arguments *in support* of this proposition are:

The AMA Guides espouse the philosophy that all impairments, no matter how small, affect the whole person and should be "expressed" as whole person impairment. Proponents argue that the same standard for measuring impairment be applied to all cases. Further, the Legislature did not intend to favor persons with scheduled impairments such that they would receive greater benefits than those with whole person impairments.

Example: worker who suffers 26% loss of use of the ring finger at the proximal joint would be entitled to receive up to $120,000.00 in combined temporary and permanent partial disability benefits, while the worker sustaining a whole person impairment of 25% or less would be subject to the $60,000.00 cap.

Arguments *against* conversion of a scheduled impairment to whole person for purposes of defining the cap are:

While the AMA Guides are mandated for use in this system to insure consistency in the evaluation of impairment, the rating itself does not constitute a permanent partial disability award, but is a factor in the computation of the award. The General Assembly provided distinct formulas for converting scheduled and whole person impairment ratings into awards for compensation.

Utilizing the 26% impaired ring finger example, 26% loss of use of the ring finger equates to a $273.00 permanent impairment award. That would mean the injured worker would have to incur wage loss benefits in the amount of $119,727.00 to reach the 120,000 cap (and $59,727.00 to reach the $60,000.00 cap, for an impairment of 25% or less). If the injured worker is receiving periodic benefits at the maximum compensation rate of $493.08, s/he has been off work in excess of nearly five years (on a ring finger injury). While this is an unlikely scenario, injuries which reach the 60 or $120,000.00 threshold are distinguished by significant levels of wage loss, impairment, or both.

Questions of equity related to scheduled and whole person impairment were addressed by both the General Assembly and the courts in the years following enactment of SB91-218. Had these bodies intended conversion of scheduled impairment to whole person for the sole purpose of limiting benefits to the lower cap, they would have done so.

Applying the cap to a whole person impairment award where none statutorily exists, then admitting for the scheduled impairment rating, equates to claiming an offset against benefits that are not admitted or owed.

In November, 1997, the issue went to hearing on a 29% scheduled impairment. Administrative Law Judge Conway Gandy decided that the plain wording of the statute applies to percentage of impairment, and found that "the limitation applicable to the claimant's 29% upper extremity impairment is $120,000.00, since such impairment is greater than 25%....". The case is under appeal.

Other items of interest:

The Claims Services Section will be reviewing criteria for error letters (that is, what constitutes an error on a General or Final Admission requiring revision). If you have examples of letters you've received which may warrant discussion or criteria you'd like to suggest, please send those to my attention. We are presently testing the current system and welcome your comments and suggestions.

Work Related Injuries in Colorado 1995
by Marty McReynolds, Manager, Research and Statistics

The Research and Statistics Unit of the Division has published a report on ***Work-Related Injuries in Colorado 1995***. This report includes the type of information contained in previous reports, such as injuries by county, part of body, gender, age, etc., plus several new exhibits describing patterns of admissions and denials.

You may request a copy of the 35-page publication by calling the Research & Statistics Unit at 575-8805, or by faxing your request to the same unit at 575-8892. Please be sure to request the ***Work-Related Injuries in Colorado 1995*** publication and provide a complete mailing address. The first copy is free, as long as supplies last. However, we do request that those who receive a copy, fill out and return the 6-question survey regarding the report. We want to be sure that future publications include genuinely useful information.

EDI, The Wave of the Future
by Jim Eldridge, Manager, Administrative Operations

EDI (Electronic Data Interchange)has become a major factor in how we review data collection by this agency. Earlier this year we began receiving Employers' First Reports of Injury electronically from the Colorado Compensation Insurance Authority , Kemper, Cigna, and Liberty Mutual. This accounts for 43% of all First Reports received by the Division. We will begin a pilot with the University of Colorado in the very near future.

The largest benefit of EDI is the turn around time for obtaining a worker's compensation number. At close of business each day, the First Reports are transmitted from the carriers to an electronic mail box. Our computer processes them into the Division system and sends an acknowledgment to the carrier along with a worker's compensation number the same evening.

Other benefits include ability to meet time lines required by statute, reduction of duplicate claims, data accuracy on both ends, and less paper.

The Division is seeking more volunteers to participate in this exciting endeavor. If you are interested in processing claims electronically or if you just would like to learn more about EDI, call Lori Ganni at (303) 575-8794 to get more information.

1998 Workers' Comp. Medical Fee Schedule Changes
By Debra Northrup, Manager, Medical Cost Containment

Creating a reasonable fee schedule to provide access to quality care for injured workers and at the same time contain medical cost is difficult. Physicians change their behavior according to the fees they are paid for services. Their behavior changes can be in the form of performing more and/or higher levels of services, and/or refusing or limiting the number of patients they accept based upon the amount of dollars they receive. The annual legislatively-mandated review and update of the Colorado Workers' Compensation Medical Fee Schedule must factor in all of these behaviors . Our method of evaluating and updating the fee schedule utilizes:

- A philosophy based upon the current health care market and worker compensation needs;
- actuarial cost evaluation and bench marking studies; and
- Task Forces and Medical Care Accreditation Advisory Committee (MCAC) to evaluate and determine reasonableness of any fee schedule proposal.

Philosophy Used to Develop the 1998 Rule Change(s):

- Maintain consistency with Relative Values for Physicians (RVP), July 1997 edition, published by St. Anthony Press.
- Maintain Budget Neutrality with the current fees, exact impact on any discipline of care, individual provider, or payer depending upon the pattern of services billed and/ or paid. Some providers and/or payers could experience a decrease or increase in the overall fees paid.
- Maintain and/or improve injured workers' ability to access quality care.
- The fee schedule does not determine reasonable and necessary care; it only establishes a fee. Disputes occur concerning whether the code billed represents the services rendered and, therefore, paid accurately.

1997 NCCI Actuarial Cost & Bench marking Analysis:

Normally, an actuarial study is done to evaluate whether fees should be adjusted and/or codes added or deleted. At lease one year of data need to be collected before a reasonable workers' compensation cost impact or benchmark analysis can be completed. The results of the 1997 analysis were as follows:

Total estimated cost impact of .03% savings.

The Workers' Compensation Medical Fee Schedule changes overall are estimated to reimburse:

29% higher than Medicare
2.58 % lower than Large Colorado Managed Care Organization
41% lower than what 70% of physicians are billing for the same services.

Task Forces and Medical Care Accreditation Advisory Committee (MCAC)

Currently, there are three task forces that address fee schedule issues: Hospital, Medical Fee Schedule, and Physical Medicine. All of the task forces, as well as the MCAC consist of payers, providers, injured worker representatives, and labor representatives. All proposed fee schedule rule change(s) are presented to one of these task forces and the MCAC for review, comment, and/or recommendations. The task forces and the MCAC received a copy of all studies and information used by the Division to develop the proposed changes. Congruency among the three task forces and the MCAC on issues is considered heavily. The Director considered comments and recommendation from task forces, MCAC and the rule-making hearing before finalizing the fee schedule rule(s).

Brief Summary of major fee schedule change(s) that will be effective for services rendered on or after March 1, 1998:

- Update the edition of the Relative Values for Physicians (RVP) from the 12/94 edition to the 7/97 edition.
- Convert the Physical Medicine and Rehabilitation Codes and values (97000-97999) codes from Rule to the RVP.

Update the Inpatient Hospital per diem rates and change the payment for exceptions to the per diem rates from line item coded and reimbursed to being paid at 80% of billed charges.

- Recognize the new CPT codes and values for DC and DO manipulation. These new codes have values that are much higher than current manipulation values. However, according to the RVP and RVS, Inc., these new codes include the office visit associated with the manipulation.
- Reduce outpatient facility fees from 85% of billed charges to 80% of billed charges and clarify when hospitals must itemize their billing.
- Eliminate the Relative Values for Dentists (RVD). Establish dental fees in rule and adjust individual fees for workers' compensation specific needs to enable injured workers to access dentistry services.
- Establish 20% above cost as a reasonable markup for supplies.
- Add a fee for completion of the M3 form (Physicians' MMI and Impairment Rating Report Form).
- Update the "1994 Study: Physicians as Assistants at Surgery" to the "1996 Study: Physicians as Assistants at Surgery."

Where to obtain a copy of the Colorado Workers' Compensation Medical Fee Schedule:

Relative Values For Physicians (RVP), July 1997 edition,
St. Anthony Press
1-800-632-0123

1996 Study: Physicians As Assistants at Surgery
American College of Surgeons
(202) 337-2702
Fax)202) 337-4271

Any questions, comments or recommended changes to the fee schedule may be directed to Debra Northrup, R.N., at (303)575-876, or Wayne Whitmarsh at (303) 575-8762.

COLORADO DIVISION OF WORKERS' COMPENSATION
CLAIMS SERVICES SECTION
1515 ARAPAHOE STREET
DENVER, COLORADO 80202-2117
300300046