All About Claims

Colorado Department of Labor and Employment
Division of Workers' Compensation
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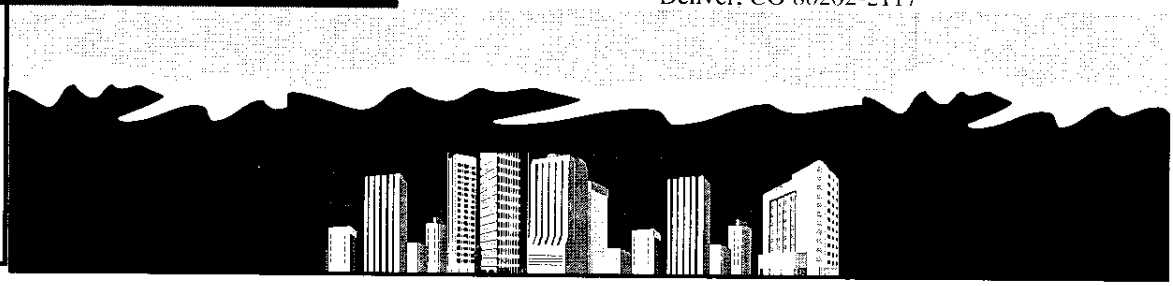


July 1999 **Volume 13**

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. Comments or suggestions for future topics may be directed to JoAnne Ibarra, Manager of Claims Services, at (303) 575-8816, or by mail at the above Division address.

1999 Workers' Compensation Legislation *by Mary Ann Whiteside, Director, DOWC*

The following is a brief summary of workers' compensation bills that have been passed by the Colorado Legislature and signed by the Governor. Information on how the law will be implemented is included in italics.

Senate Bill 99-161

BILL TITLE: CONCERNING REDUCTION OF WORKERS' COMPENSATION DISABILITY BENEFITS WHERE THERE IS EVIDENCE OF INTOXICATION

Indemnity benefits shall be reduced by 50% for claimants whose injury resulted from the use of drugs or alcohol, if a blood test shows the presence of a not medically prescribed controlled substance or alcohol level above 0.10%. Such test result shall create a rebuttable presump- tion that the drugs or alcohol caused the injury, which may be overcome by clear and convincing evidence. The "Notice to Employer of Injury" poster language for injuries on or after 7/1/99 is amended to reflect this change. *Modification of admitted temporary disability benefits must occur under Rule IX.D or through administrative hearing. In addition, claims handlers are asked to utilize the Remarks section of the Final Admission of Liability form to explain the basis for the reduction in benefits.*

House Bill 98-1037

BILL TITLE: CONCERNING MILEAGE ALLOWANCE FOR STATE OFFICERS AND EMPLOYEES

This bill which was signed into law in 1998, provides for reimbursement of mileage for state employees at a rate of twenty-eight cents per mile. It takes effect July 1, 1999. Its relevance to workers' compensation is found under Rule XVIII.F.5. which sets the reimbursement rate for injured workers to be the prevailing rate of travel reimbursement provided to state employees. *No rule changes anticipated.*

House Bill 99-1049

BILL TITLE: CONCERNING THE PROCEDURAL REQUIREMENTS FOR THE SELECTION OF AN INDEPENDENT MEDICAL EXAMINER IN CASES OF DISPUTES UNDER THE "WORKERS' COMPENSATION ACT OF COLORADO"

In the selection system for a division independent medical examination (IME), the division currently allows parties to obtain a list of three IME physicians and each party may strike one name. This bill changed the procedure and requires the division to select only one IME from a list of IMEs maintained by the division. The bill also states that the IME selection process is applicable to all open cases with a date of injury on or after 7/1/91. This bill will be effective 9/1/99 unless a referendum petition is filed. *(For more information on how the process works, see HB 1049 Frequently Asked Questions & Answers, on page 5.)*

House Bill 99-1105

BILL TITLE: CONCERNING CRITERIA FOR PAYMENT OF TEMPORARY TOTAL DISABILITY WORKERS' COMPENSATION BENEFITS

If it is determined that a temporarily disabled employee is responsible for termination of employment, the resulting wage loss shall not be attributable to the on-the-job injury.

cont. on page 2

WORKERS' COMPENSATION FORMS NOW AVAILABLE ON THE INTERNET
Visit our website at:
http://workerscomp.cdle.state.co.us
for current Workers' Compensation information.

House Bill 99-1105 cont.

This applies to injuries on or after 7/1/99. *Termination must be sought under Part D of Rule IX. Suspension, Modification or Termination of Temporary Disability Benefits by a Petition or through fact-finding hearing.*

House Bill 99-1107

BILL TITLE: CONCERNING CAUSATION IN CASES OF PERMANENT DISABILITY UNDER THE "WORKERS' COMPENSATION ACT OF COLORADO"

(1) The fact that an employee suffered a previous disability *or impairment* or received compensation therefor shall not preclude compensation for later injury or death.

(2) If the employee is permanently and totally disabled and has a previous disability, the percentage of disability for the subsequent injury is calculated by computing the percentage of the entire disability and deducting the percentage of the previous disability as it existed at the time of the subsequent injury. This section shall not apply to cases in which the provisions of the Subsequent Injury Fund are applicable.

(3) If there is an award for benefits, the award shall exclude any previous impairment to the same body part. This section shall not apply if the provisions of the Subsequent Injury Fund are applicable. *See Rule XIX.C*

House Bill 99-1157

BILL TITLE: CONCERNING THE REESTABLISHMENT OF AN EXCLUSIVE SCHEDULE FOR PERMANENT PARTIAL DISABILITY UNDER THE WORKERS' COMPENSATION LAW, AND, IN CONNECTION THEREWITH, INCREASING THE AMOUNT OF BENEFITS RECEIVED UNDER THE SCHEDULE AND LIMITING BENEFITS FOR MENTAL STRESS.

(1) Increases scheduled award for permanent partial disability from $150 to $176 per week.

(2) Allows annual increase/decrease of the compensation rate to equal the state average weekly wage increase/decrease beginning 7/1/2000, for claims on or after that date.

(3) If an injury results in a scheduled injury and medical impairment, scheduled injuries shall be compensated on the "schedule", and nonscheduled injuries shall be compensated as medical impairment benefits. Benefits from a mental impairment shall not be combined with a scheduled or nonscheduled injury. The definition of "mental impairment" includes only recognized, permanent psychological disabilities. The definition does, however, include a disability which arises from an accidental physical injury that leads to a recognized permanent psychological disability. Medical impairment benefits resulting from mental impairment are limited to twelve weeks, except that this limitation does not apply to any victim of a crime of violence nor to the victim of a physical injury or occupational disease that causes neurological brain damage. This bill is effective for injuries on or after 7/1/99. *No rule changes are anticipated.*

House Bill 99-1157 cont.

House Bill 99-1164

BILL TITLE: CONCERNING THE CREATION OF INCENTIVES TO PREVENT RECEIPT BY INMATES OF ILLEGAL PAYMENTS UNDER PUBLIC PROGRAMS

The county sheriffs, the Department of Human Services, County Departments of Social Services and the Department of Labor and Employment are required to develop a system to identify persons receiving payments while incarcerated. If the information results in termination of compensation benefits, the carrier shall pay a reward equal to 10 % of one week's benefits to the sheriff. An individual who is ineligible shall repay amounts received. *No rule changes anticipated.*

House Bill 99-1269

BILL TITLE: CONCERNING THE REDUCTION OF WORKERS' COMPENSATION BENEFITS IN CASES WHERE A CLAIMANT MAKES A MATERIALLY DECEPTIVE STATEMENT THAT WILLFULLY MISLEADS AN EMPLOYER AS PART OF THE JOB APPLICATION PROCESS CONCERNING THE PHYSICAL ABILITY OF THE CLAIMANT TO PERFORM THE REQUIREMENTS OF THE JOB

If the employee willfully misleads an employer concerning the physical ability to perform the job, and the employee is subsequently injured as a result of the physical ability about which the employee misled the employer, compensation benefits shall be reduced by 50%. This shall apply in addition to any other penalty for false statements. This is effective for injuries on or after 9/1/99, unless referendum is filed. *Modification of admitted temporary disability benefits must occur under Rule IX.D or through administrative hearing. No changes to Rule IX are anticipated. In addition, claims handlers are asked to utilize the Remarks section of the Final Admission of Liability form to explain the basis for the reduction in benefits.*

House Bill 99-1278

BILL TITLE: CONCERNING ADMINISTRATIVE HEARINGS IN WORKERS' COMPENSATION CASES CONDUCTED BY ADMINISTRATIVE LAW JUDGES

This bill states that the Colorado Rules of Evidence and requirements of proof for civil non-jury cases in district courts shall apply in all hearings. The bill was effective on signature at 1:18 P.M. on May 29, 1999. *No rule changes anticipated.*

Got a Question?

We received a letter from a law firm regarding the on-going application of House Bill 98-1062 -- last year's legislation which changed the time frame for objecting to Final Admissions of Liability and set requirements for disputing MMI and whole person impairment. Sue Warren, Manager of Medical Services Delivery at the Division, reviewed the issues as presented. Her response is in italics.

Q. Scenario: Insurance Company A files the Final Admission of Liability on January 1, 1999. The Claimant files an Objection to the Final Admission of Liability and a Notice and Proposal to Select a Division IME Physician on January 6, 1999. Respondents indicate in correspondence that neither of the doctors proposed by the Claimant are acceptable to Respondents on January 6, 1999. Claimant next files a Request for Division IME on February 10, 1999. The Request for Division IME is filed approximately 36 days subsequent to the filing of the Notice and Proposal to Select Division IME Physician, and 40 days subsequent to the filing of the FAL.

Please explain if Claimant has missed the time period in which to request a Division IME. Does it make any difference in terms of the time period the Claimant has to file a Division IME whether or not the Respondent corresponded on January 6, 1999 that the doctors submitted by the Claimant were insufficient [not acceptable]?

A. *You relayed a case scenario and asked about the time frames that apply in the statute. Your question presents an issue that is fact dependent. The parties may seek dispute resolution in order to determine the correct interpretation of the bill. I've set forth my understanding of the applicable statutory time limits in my response to the next question. The major issue is from what date in each process does the counting being? That issue depends on the facts of an individual situation. For example, was the January 6 letter a counter offer or did the Claimant have reason to believe there would be a counter offer and s/he was still operating within the initial 30 day time frame?*

Q. What is the effect if the Insurer doesn't notify the Division that no doctor has been chosen?

A. *The statute does not provide a remedy in these situations. Whether or not penalties or other remedies would be allowed is an issue that would have to be determined by an administrative law judge. Please note that the rules provide that if the insurer does not file such a notice with the Division, the claimant may do so as part of the application for IME.*

Q. Does the Claimant have 30 days to file the Notice of Proposal, 30 days to negotiate a doctor, and an additional 30 days to file a Request for Division IME? Please clarify how many days the Claimant has in which to file a Request for Division IME, after he has filed a Notice and proposal and there is either no agreement or no response.

A. *A. The notice and proposal for an IME doctor must be given within 30 days after the date of mailing of the final admission to the claimant (or the date of mailing or physically delivering the disputed finding to the insurer).*

B. The parties have 30 days from the date of mailing of the notice and proposal in which to negotiate selection of a doctor.

C. The insurer must give written notice of the failure of the parties to agree to the Division within 30 days of the date on which the parties disagreed (or were ultimately nonresponsive).

This complete scenario allows for up to 90 days for the whole process to be completed between the parties. Whether or not this amount of time will actually be allotted will, in my opinion, depend upon the facts of each case. Again, disagreements about timing may be brought to the administrative law judges for resolution

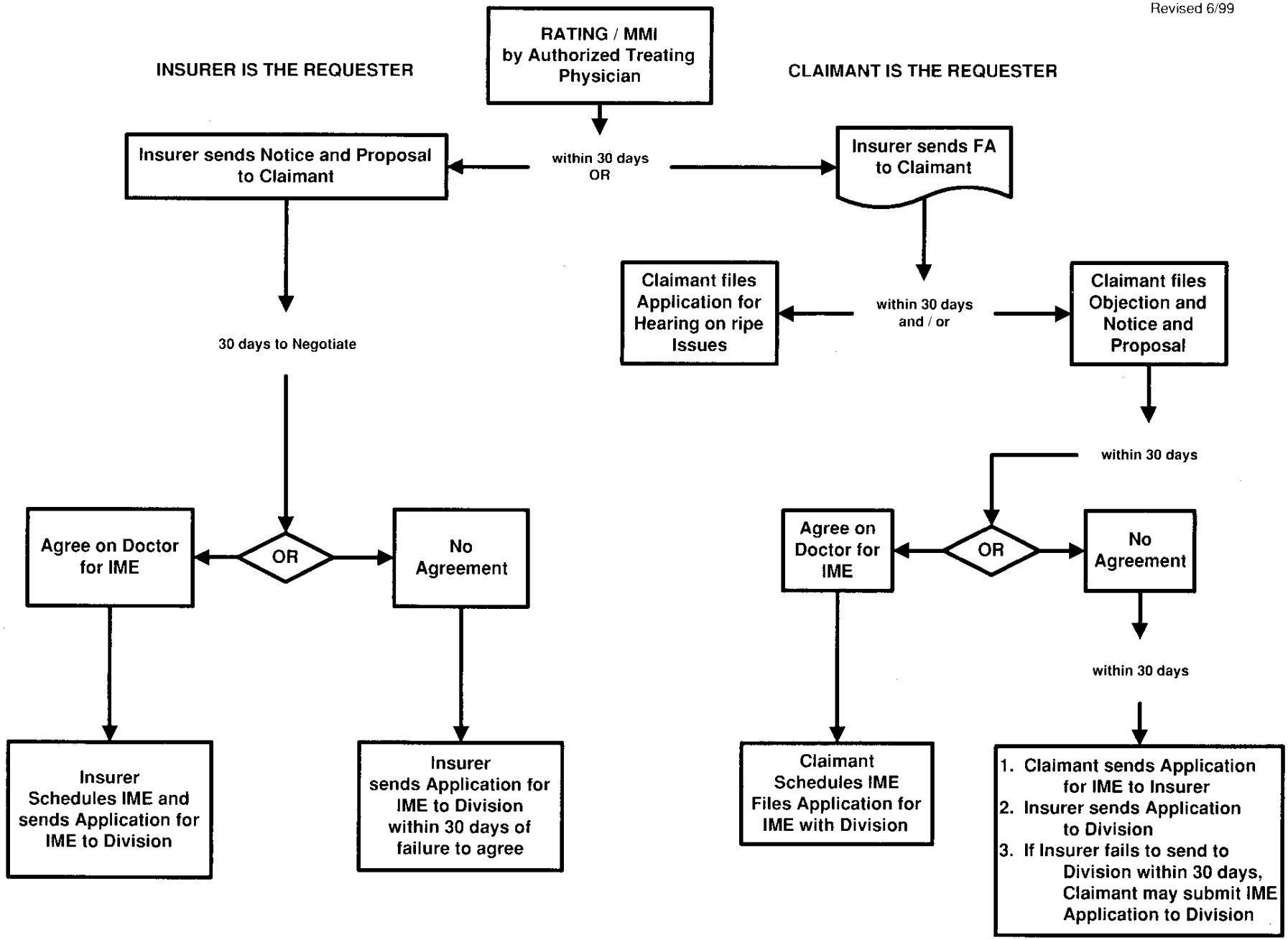
Q. If the parties stipulate to a doctor who is not a panel physician to perform a Division IME, will the Division still act on behalf of the parties? Does the $450 fee apply or can the doctor charge whatever the doctor wishes to charge? If the report is late, will the Division inform the doctor that the report is late? If the report is incomplete, will the Division inform the physician that the report is incomplete?

A. *You asked whether or not the Division will be involved in IMEs where the parties have agreed upon a physician, and have not filed a Division application for IME. The Division has no jurisdiction under HB98-1062 or previous law to administer a system of private IMEs. The Division does not monitor time frames or other program criteria in these cases. We do recommend that the parties use our forms and the established time frames for conducting the private IME. This would lend consistency to the proceedings for all involved parties, and could prevent confusion. There was a rule change last year that provided that the $450 fee for IMEs would apply to private IMEs as well as Division IMEs, so the amount that can be charged is still limited.*

For additional information on this process, see Final Admission/Objection Process, on page 4.

Final Admission/Objection Process

Revised 6/99



HB 99-1049 Frequently Asked Questions & Answers

Q.What does House Bill 99-1049 provide?

A. This legislation changes the IME selection process, in that the Division will provide only one physician name when an Independent Medical Examination (IME) is requested.

Q. When does HB 99-1049 become effective ?

A. HB 99-1049 becomes effective September 1, 1999, if no referendum is filed.

Q. What cases does it apply to?

A. It applies to injuries occurring on or after July 1, 1991 where no IME has previously been requested.

Q. What about requests for IMEs pending on or after September 1, 1999?

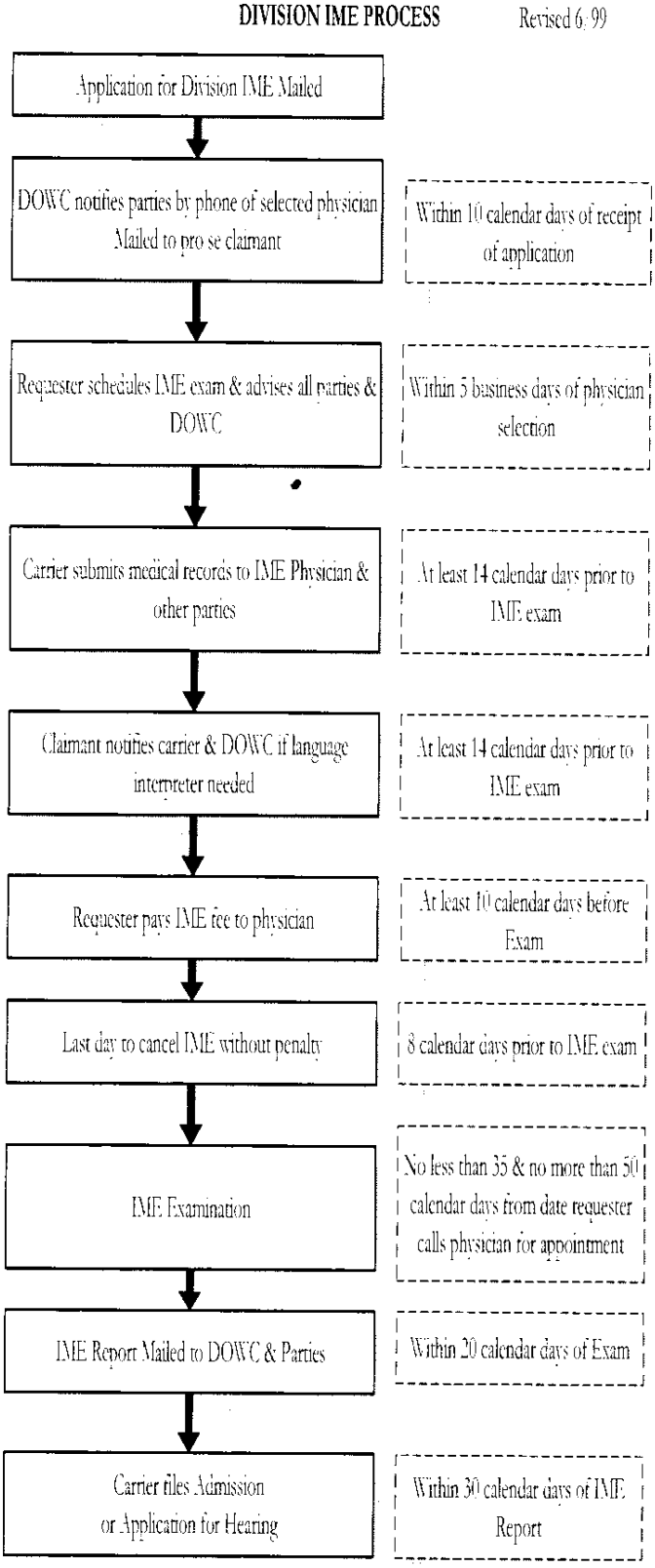
A. In any case with a date of injury on or after July 1, 1991, in which an IME physician must be assigned by the Division after September 1, 1999, only one name will be provided to the parties.

Q. So, how do the changes in HB 99-1049 effect the provisions of HB 98-1062?

A. HB 98-1049 added new language to §8-42-107.2(6): *"This section effected procedures related to the selection of an IME and shall be applicable to all open cases with a date of injury on or after July 1, 1991, for which a division IME has not been requested, pursuant to section 8-42-107."* Thus, the 1999 statutory changes in §8-42-107.2 apply only to the *procedures* relating to the *selection of an IME* for injuries on or after July 1, 1991, and have no effect on these cases with regard to other provisions of H.B 98-1062, [see section 8-43-203 (2)(b)(II)].

Q. Will the Division continue to consider issues such as geographic location in the selection of IMEs?

A. HB 99-1049 provides that the division's selection of an IME: be **". . . random from the pool of IME candidates."** Within the context of the workers' compensation act, and specifically the purpose of the IME process, it is necessary to pull together a "pool" of candidates to perform a specific, individual IME based on established selection criteria. Therefore, in order to have a logical pool of IME physicians for an individual IME, "random" must be interpreted to allow application of three criteria prior to the random selection of one doctor from the resulting list. The three criteria are: 1) geographical location, 2) area of expertise or specialization, 3) a conflict check to assure that neither the doctor nor the facility with which the doctor is associated has prior involvement with the claimant, such as being the authorized treating physician. This was discussed previously with the bill's sponsor and met with his approval.



Timely Payment of Medical Benefits: What Can be Done? *by Debra J. Northrup, RN*

"I've not been paid for my services in the past six months." Sound familar? Well it certainly was familar to the Division. Unable to identify the causes, the Division addressed the issue by meeting and talking with experts in the various types of medical billing, medical bill review and payment.

The following chart emerged to clarify the most significant problems and issues encountered. This chart is meant for distribution to health care billers, reviewers and payers as a resource tool to address the most common problems from the timely payment scenairos.

Please feel free to share this chart to promote education and payment of authorzed care medical bills within 30 days. The more we work together to rid the system of procedural issues, the more time we can spend on "complex" workers' compensation issues.

As always, please feel free to advise me of any emerging problems and potential solutions you may have to expedite medical billing, bill review and payment.

MOST COMMON TIMELY MEDICAL PAYMENT ISSUES
Workers' Compensation Health Billing Payment and Dispute Resolution Process

ISSUE	PROCESS	APPLICABLE RULE/DOWC COMMENT
	PRIOR AUTHORIZATION OF SERVICES	
Prior authorization	When requesting prior authorization, providers must explain the medical necessity of the service and submit supporting documentation. The request must be as specific as possible.	Rule XVI,I.2.d
Lack of authorization from adjuster	All authorization given to a provider should be specific, in writing, and internally routed to the bill reviewer and all other parties for proper handling of bill.	Rule XVI, I, 3, Division's recommendation
Denial of authorization	All denials of prior authorization must be in complete compliance with Rule XVI, J	Rule XVI,J - allows for automatic authorization if denial is not done timely. Rule XVI, I, 3: Unreasonable denial may lead to penalties.
	PRIOR TO SUBMITTING BILLS	
Incomplete or inaccurate bills	Before sending the bill, the provider should verify the billed information on the HCFA 1500 to insure the fields are properly filled out and the information is correct.	
Provider tax info not available or wrong	Providers should verify the tax ID number	
Provider specialty not identified on bill	Bill for only one provider per HCFA 1500 form. Block 31 of the HCFA 1500 may be used to identify the supervising provider, and block 19 used to identify the provider rendering the treatment, if different than the supervising provider.	
Provider's submission of notes and supporting documentation	The Division recommends submitting all billing documentation at the time of submitting the bill unless a private agreement exists between parties.	Rule XVI, G, Required Billing Forms and Accompanying Documentation, 5, b: A Division form titled "Physician's Supplemental Report" (WC-M2) or a copy of the provider's office notes related to the visit is required when substantial change is made to an existing treatment plan or when treatment exceeds the medical treatment guidelines.
Hospitals are charging for copies of records	The payer's request for records from the hospital needs to be specific. Ex.: A physician's billed ER visit only requires the physician's ER Room note, not the entire hospital chart, to evaluate the services billed.	
Hospitals are not releasing records	Records may not be necessary for bill review. The hospital audit procedure may be appropriate if questioning the extent of services provided.	Rule XVI, M

ISSUE	PROCESS	APPLICABLE RULE/DOWC COMMENT
Provider PPO discounts taken w/o a signed contract or the contract agreement has expired.	Payers need to verify payment reductions are in compliance with PPO contracts.	Rule XVI, I, 2, d Rule XVI, I, 3
	REVIEW AND PROCESSING OF BILLS	
No acknowledgment of receipt of bill	Within thirty days of receipt of a bill, payer should notify the billing provider, either by EOB or letter, of all bills received, even if the claim has not been established, the bill has been submitted to the wrong insurer, or the services billed are non-work related.	
Unestablished Claims - "First Report of Injury" has not been filed in a timely manner or the medical services billed are non-work related.	In cases of unestablished claims (no "First Report of Injury"), the provider should inform the patient of the need to file a claim with DOWC.	C.R.S. §8-42-101(4)
	Payer internal documentation routing should not necessitate a second request for documentation and/or a bill going unpaid.	Rule XVIII - Any second request for medical records by the payer should generate a copying fee billed by the provider and paid by the payer. Requests for second copies of documentation will be compensable at the rate established in Rule XVIII.
	The payer verifies all billed codes/modifiers, policy number, etc. and issues a reimbursement check and an explanation of benefits (EOB) within 30 days from receipt of bill.	Rule XVI, K, 2, b
	Payers must pay for the services as billed or deny the codes/modifiers not supported by the presented documentation and/or Relative values for Physicians/DOWC rules. Payers are required to be very clear and specific on why they are denying the billed codes. Payers cannot change billed codes. The provider has 60 days to resubmit the denied codes and modifiers with additional information.	Rule XVI, K, 2, b, but we could include the modifiers as outlined in RVP. The Division is assessing and evaluating various mechanisms for communicating with the public.
	PAYMENT OR DENIAL OF PAYMENT RECEIVED	
	The provider should contact the payer if no check or EOB is received within 30 days to verify receipt of bills and to cross-verify accuracy of the bill.	No action is required.
Re-review of claims	The provider has 60 days to contest reasons for non-payment and present their argument	Rule XVI, K, 2, b, 7
	Payer has thirty days from receipt of resubmission to pay or explain continued denial.	Rule XVI, K, 2, b, 7
	DISPUTE RESOLUTION	
Disputes	Any issues unresolved between the parties may be brought to the Division's Mediation Unit to identify the issues and mediate a resolution. Mediation Process: The Mediation Unit may contact the Medical Cost Containment Unit for interpretation of applicable RVP or Rule. Unresolved disputes may follow the procedures in Rule VIII.	Mediation: 303-575-8730

COLORADO DIVISION OF WORKERS' COMPENSATION

LEVEL II PHYSICIAN'S ACCREDITATION & RE-ACCREDITATION SEMINAR

The Colorado Department of Labor and Employment will hold a **Level II Physician's Accreditation and Re-accreditation seminar** through its Worker's Compensation Division on **October 8 and 9 in Glenwood Springs, Colorado.** This seminar is for physicians who are already accredited within the system, and for physicians wishing to become accredited. The seminar will feature lectures and workshops by expert speakers on the subjects of impairment rating methodologies and the Colorado Treatment Guidelines. The course utilizes the Guides to the Evaluation of Permanent Impairment, Third Edition, Revised, published by the AMA.

The cost of the seminar is $325.00 for those re-accrediting, and $375 for those seeking accreditation for the first time. To obtain a registration form or for more information contact the Physician's Accreditation Program at (303) 575-8763.

A home study process is available as well for physicians unable to attend a seminar.

Physicians not accredited may attend this seminar in order to accredit. ***Testing will be required immediately following the seminar*** for this purpose. ***Prior study of the curriculum and guides would be necessary, as this seminar does not address all aspects of that curriculum.***

Inside this edition of ***All About Claims***

Introduction to Workers' Compensation

Videos for injured workers will be available for viewing beginning August 1999. Initially the videos will be shown at the Division on request and can be viewed in English or Spanish.

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