ALL ABOUT CLAIMS

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The purpose of this newsletter is to provide information to the Colorado workers' compensation adjusting community. Here are some highlights of articles you'll see in this edition: ICAP and the Appellate Process is an overview of the role of ICAP and the scope of the panel review on decisions under appeal. Appeals Examiner David Cain, who also authors a bar association column on Colorado workers' compensation issues, penned this article with the claims adjusting audience in mind. Effective transmission of documents to the Division or, How to Get a W.C Number is the subject of an article by DOWC's Document Entry Manager, Lori Ganni. An Update on Rules IV and IX, which went into effect on November 30, 1996, along with a desk reference on Situations Requiring Prior Authorization are also included. Questions or comments regarding this newsletter may be referred to JoAnne Ibarra, Manager of Claims Services, at (303)575-8816. We would particularly like ideas on topics for future issues.

ICAP and the Appellate Process
by David Cain, Appeals Examiner, ICAP

The Industrial Claim Appeals Panel (ICAP) was created in 1986 to conduct appellate review of hearing officer decisions in unemployment insurance cases and administrative law judge (ALJ) decisions in workers' compensation cases. Because of ever increasing litigation costs, including the cost of appeals, adjusters should have a basic understanding of ICAP's function and process. Knowing whether to appeal an ALJ's order, and the prospects for success, can be as important as deciding whether to settle a claim or proceed to a hearing.

The Distinction Between Fact and Law

ICAP's authority to review an ALJ's decision is set forth in §8-43-301(8). The statute permits ICAP to "correct, set aside, or remand" an order, but only under limited circumstances. ICAP may not interfere with an ALJ's "findings of fact" unless they are unsupported by "substantial evidence." However, ICAP may remand or reverse an order if the ALJ has incorrectly applied the law, or if the ALJ failed to make sufficient findings to indicate the basis of the order.

As a practical matter, the "substantial evidence" standard makes it nearly impossible for ICAP to reverse an ALJ's decision to believe one witness over another, or the ALJ's decision to choose one of several possible interpretations of the evidence. For instance, a claimant might testify that he cut his hand at work on June 23, and the respondents might produce the claimant's supervisor to testify that the claimant did not work on June 23. If the ALJ believes the claimant, ICAP would have no grounds to reverse the award of benefits. This would be true even if the evidence also showed that the claimant had a history of filing false claims.

It follows that appeals based on the assertion that the ALJ should have viewed the evidence differently are generally a waste of time and money. Because parties are often psychologically committed to their own assessments of the evidence, it is difficult for them to recognize the possibility of contrary interpretations. However, a wise adjuster will always consider whether a potential appeal is purely factual, and not worth the money.

In contrast to factual issues, appeals based on issues of law are more likely to succeed at ICAP. Legal issues frequently involve questions of statutory interpretation. An example of such a question is whether the twelve week limitation on "medical impairment benefits" found in the stress statute applies to temporary disability benefits as well as permanent partial disability benefits. Because the Workers' Compensation Act is frequently amended, novel issues of statutory construction arise often.

Other types of legal issues concern the conduct of the proceedings themselves. For example, questions may arise about the propriety of an ALJ's decision to admit or exclude evidence at a hearing, or an ALJ's refusal to grant a continuance to receive recently discovered evidence. Although ALJs possess broad discretion in the conduct of hearings, ICAP will review the proceedings to insure that they reflect fundamental fairness and compliance with the applicable rules and statutes.

How ICAP Functions

ICAP currently consists of five lawyers whose statutory title is "Appeals Examiner." However, only two members of ICAP devote their full time to workers' compensation cases. The reason for this division of labor results from the fact that, although workers' compensation appeals are usually more complex than unemployment insurance appeals, there is a much greater volume of unemployment appeals. For instance, in fiscal 1995-1996, ICAP decided 452 workers' compensation appeals and 1,843 unemployment appeals.

Generally, when a workers' compensation appeal is received it is assigned to one of the two examiners handling workers' compensation cases. That examiner then reads the briefs and record, prepares a proposed order, and then gives the file to another examiner for review. The reviewing examiner may concur in the proposed decision or, as often happens, suggest revisions or changes. On rare occasions, the two examiners may fail to reach an agreement and a third examiner is called in to break the deadlock.

Section 8-43-301(8) requires that ICAP issue its decision within sixty days of receiving the record in workers' compensation cases. ICAP scrupulously adheres to this requirement, and parties can expect a decision within that time frame.

The Significance of ICAP Decisions

ICAP has no formal "policy" or mission statement. However, it is safe to say that all of the examiners consider it their duty to issue high quality legal decisions in a timely fashion.

Moreover, ICAP examiners proceed with an awareness that their orders, while not possessing the precedential value of court decisions, often influence the results in cases pending before ALJs. For this reason, ICAP strives to insure that its decisions are consistent with one another, and that the law is applied uniformly, whether the hearing was held in Pueblo or Denver.

Once ICAP issues its decision, parties may elect to appeal ICAP's order to the Colorado Court of Appeals. In fiscal 1995-1996, parties appealed 179 ICAP decisions to the court, which represents approximately thirty-six percent of all ICAP orders issued during that period. During the same time frame, the Court of Appeals issued 101 decisions, affirming or agreeing with ICAP's ruling in 84 of those cases.

Presumably, ICAP orders which are appealed to the Court of Appeals represent the most difficult and uncertain issues in workers' compensation. Despite that fact, ICAP's ruling is consistent with the court's ultimate decision more than eighty percent of the time. Hopefully, this statistic reflects the quality of ICAP decisions, and affords adjusters a yardstick by which to measure the probability of success when appealing to the court.

Rule Changes: Update on Rules IV and IX
by JoAnne Ibarra, Manager, Claims Services Section

Like yourselves, we watched as changes to the statute were enacted by the 1996 General Assembly in several key areas which will directly impact the way the statute is administered. As a result of these changes, amendments to the rules were necessary. Here are some points you may want to keep in mind:

Rule IV: Claims Adjusting Requirements

A procedure for obtaining impairment ratings for out-of-state claimants was the direct result of House Bill 96-1040. In enacting this legislation, lawmakers acknowledged the inherent difficulties in adjusting out-of-state claims without providing some flexibility and procedural mechanisms for moving claims to resolution in the absence of immediate access to a level II provider. The legislature provided for the loss of permanent disability benefits to a claimant who declines to have the authorized out-of-state treating physician conduct tests as required by the AMA Guides once the physician has determined the existence of impairment, or information is not transmitted timely ***and***, in either instance, the claimant subsequently refuses to return to the state of Colorado for examination which has been arranged and paid for by the insurer. §8-42-107(8)(b.5)(I)(B), C.R.S.

HB 96-1040 also defined processes and time frames for obtaining opinions on permanent impairment. While it mirrored Rule IV(N) (4) in establishing time frames for responding to specific medical determinations, adjusters should note that the statute is even more stringent in requiring that action be taken based on date of determination of MMI. For example, if the claimant is a state resident, a carrier has 40 days from the date MMI is determined to refer a claimant for a permanent impairment evaluation if a referral is not timely made by the authorized treating physician providing primary care (who is not level II accredited and determines the claimant has sustained permanent impairment). See §8-42-107(8)(b.5)(II), C.R.S.

Also, under HB 96-1040 authority was given to the authorized treating physician providing primary care to determine, in the first instance, if the claimant has sustained no permanent impairment. In the event of such a finding, a referral to a level II accredited physician by the insurance carrier is not necessary.

Amendments to Rule IV(N) include:

1) The addition of time frames for reacting to determinations of MMI and permanent impairment for *scheduled injuries;*

2) Clarification that the requirements *apply only to those claims which are required to be filed with the division* for dates of injury on or after July 1, 1991;

3) A requirement that *any evaluation record (worksheets) associated with an impairment rating accompany a Final Admission of Liability;*

4) A requirement that the admission *"specify and describe the insurance carrier's position on the provision of medical benefits after MMI, as may be reasonable and necessary within the meaning of the Act."* In the absence of a change to the Final Admission of Liability form, adjusters are directed to use the remarks section of the current form.

Finally, Rule IV was amended to delete subsection (I) which addressed termination of permanent total benefits at age 65 based on the Colorado Supreme Court opinion in Industrial Claim Appeals Office v. Romero, 912 P.2d 62 (Colo.1996).

Substantive vs. Procedural Provisions

Great debate was heard at the rules' hearing over whether the provisions of HB 96-1040 were substantive or procedural. The overwhelming opinion was that the provisions were procedural and should apply to those cases which were pending at the time the bill became effective on April 8, 1996, and to claims accruing in the future. Rule IV(N) was modified accordingly.

> *It is true that in workmen's compensation cases, the rights and liabilities of the parties are determined by the statute in effect at time of claimant's injury. However, if there are procedural changes in a statute...the changes are applicable to all cases pending at the time the new statute became effective unless contrary intent is expressed by General Assembly.*

Kinninger v. Industrial Claim Appeals Office, 759 P.2d 766 (Colo. App. 1988).

For additional information on Rule IV amendments, see Got a Question?

SITUATIONS REQUIRING PRIOR AUTHORIZATION
MEDICAL COST CONTAINMENT
August 20, 1996

Cite	SITUATION
Rule 16 §D(1), F(2),and I(1)(c)	Service is not included in the Fee Schedule
Rule 16, §E(1)(b)	Service performed by a provider not defined as a physician or non-physician provider per Rule. Providers recognized by rule are: physicians licensed by the State of Colorado through the Board of Medical Examiners, Board of Chiropractic Examiners, Podiatry Board and Board of Dental examiners, and non-physicians licensed or registered by the State or a recognized national entity including audiologist, acupuncturist, licensed clinical social worker, licensed practical nurse, licensed professional counselor, marital and family therapist, nurse practitioner, occupational therapist optometrist, orthopedic technologist, psychologist, physical therapist, physician assistant, registered nurse, respiratory therapist, speech pathologist, and surgical technologist.
Rule 16, §E(3)(a)	Injured worker referred to out-of-state provider.
Rule 16, §E(4)	Exceeding Fee Schedule by out-of-state provider.
Rule 16, §I(1)(a)(as proposed)	Service exceeds recommended limitations for that service as set forth in Treatment Guidelines or the Guidelines otherwise require prior authorization.
Rule 16, §I(1)(b)	Service is identified in the Fee Schedule as requiring prior authorization.
Rule 18, §E(1)(b)(1) Surgical Section.	Procedures that the American college of Surgeons' 1994 Study: Physicians as Assistants at Surgery (7/25/94) (the publication) restricts assistants to "almost never" or procedures not referenced in the publication.
Rule 18 §E(1)(b)(3) Surgical Section	Use of more than one assistant surgeon or more than one minimum assistant surgeon.
Rule 18, §E(2)(e) Radiology Section	Thermography services if the requested study does not meet the indicators for thermography outlined in this radiology section
Rule 18, §E(4)(a) Medicine Section	Biofeedback, codes 90900 through 90915, after 8 visits.
Rule 18, §E(4)(b) Medicine Section	Psychiatric/Psychological services, more than 6 visits.
Rule 18, §E(4)(d) Medicine Section	Initial evaluation for delayed recovery which exceed following limitations: Evaluation Code 90801--limit 4 hrs; Testing Code 90830--limit 6 hrs; and Psychotherapy Codes 90841 through 90844--limit 50 minutes/visit.
Rule 18, §E(5)(Special Note to all Providers) Physical medicine Section.	Physical medicine treatment exceeding the Treatment Guidelines
Rule 18, §E(5)(Special Note to all Providers) Physical Medicine Section.	Physical medicine treatment not covered in the Treatment Guidelines and exceeding 60 days from the initiation of treatment

Rule 18, §E(5)(a){Physical Medicine Section. Also, in all treatment Guidelines.	Acupuncture. Evidence of training, registration and/or certification of provider may be required.
Rule 18, §E(5)(b)Physical Medicine Section.	Chronic Pain Programs and Back Schools. Must be established in writing by mutual agreement of payer and provider prior to initiation of care.
Rule 18, §E(5)(e) and (f) Physical Medicine Section.	Level I and/or Level II procedure exceeding in combination 1-hour/day. Provider's medical records must reflect medical necessity. Procedures include: aural/vestibular, cognitive retraining, fabrication/modification of orthotics, gait training (complex), joint mobilization, neurodevelopmental activities psychosocial adaptation, nueromuscular re-education, prosthetic training, reflex/sensory integration, soft tissue mobilization speech language treatment, sterile Hubbard tank/whirlpool, and surface electromyogram.
Rule 18, §E(5)(g) Physical Medicine Section.	Manipulation, if treatment exceeds 36 visits
Rule 18, §E(5)(I) Physical Medicine Section	Complex office visit for therapist per discipline of care per injury.
Rule 18, §E(5)(j) Physical Medicine Section.	Special Tests exceeding 2 hours, except for functional capacity assessments and work capacity evaluations exceeding 4 hours.
Rule 18, §E(5)(n) Physical Medicine Section.	Work Hardening, maximum allowable daily charge is 30 RVU.
Rule 18, §E(5)(o) Physical Medicine.	Work simulation, maximum allowable daily charge is 30 RVU.
Rule 18, §E(8)(a)(2)(d) Hospital Services.	Non-emergency in-patient admissions.
Rule 18, §E(8)(b)(1) Hospital Services Section.	Non-emergency in-patient surgery.
Rule 18, §E(9) Home Therapy Section.	At home therapy.