Interpretive Bulletins

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

Utilization Review & Requests for Hearing

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Questions have arisen as to whether a party may request a hearing to obtain a change of physician absent a utilization review. The utilization review (UR) and hearing sections at 8-43-501 and 8-43-207, respectively, are separate dispute resolution articles under the Colorado Workers' Compensation Act.

In reviewing these provisions, it is clear the General Assembly took great care to articulate a purpose for utilization review and define it as "a mechanism to review and remedy [medical] services rendered…which may not be reasonably necessary or reasonably appropriate according to accepted professional standards". Utilization review was intended as a peer review process undertaken by three medical professionals designated by the Division, to independently review medical records and determine whether the treatment afforded was appropriate based on recognized standards of medical care. Their individual recommendations are forwarded to the Director and afforded great weight in deciding issues of change of provider, retroactive denial of fees, and revocation of a physician's accreditation.

Administrative hearing by contrast, differs in scope on the issue. A hearing in a change of provider dispute does not evoke a process whereby a medical peer group evaluates a request for change of physician, based on a complete review of the medical record

specific to the question of medical efficacy. It does, however, afford the parties full opportunity to present evidence and seek resolution within a reasonable time frame, long before issues of medical utilization become tantamount. Timely resolution is critical to cost saving efforts, but once utilization review has been requested on an issue, a hearing may not be requested on that issue, pending completion of the UR. The purpose is to assure administrative and judicial efficiencies:

> When an insurer, self-insured employer, or claimant requests utilization review, no other party shall request a hearing pursuant to section 8-43-207 until the utilization review proceedings have become final, if such hearing request concerns issues about a change of physician or whether treatment is medically necessary and appropriate. *See* §8-43-501 (2)(e), C.R.S. 2001.

To clarify, a party may request a hearing to address the issue of change of physician, reasonable and necessary medical care, etc., without having first requested a utilization review. In fact, in cases where a utilization review results in a recommendation for retroactive denial of fees to a provider, the Director will consider previous efforts by the claims administrator to mitigate losses through requests for a change in provider and raising the issue of reasonable and necessary medical care. The legislative purpose for active management of claims and timely provision of quality medical care is furthered by allowing parties, whether claimant or respondent, to request a change in provider by hearing rather than requiring a utilization review.