

**DEPARTMENT OF LABOR AND EMPLOYMENT  
DIVISION OF WORKERS'  
COMPENSATION**



***LEVEL I ACCREDITATION  
CURRICULUM***

## INDEX

Chronology of a Workers' Compensation Case .....	p. 3
“To Whom am I Responsible in the Workers' Compensation System?”.....	p. 8
Determining Causality .....	p. 12
About the Workers' Compensation Rules .....	p. 41
Billing in the Workers' Compensation System .....	p. 49
Impairment .....	p. 77
Codes of Ethics .....	p. 79
Quality Workers' Compensation Reporting .....	p. 90
Timely Payment Issues .....	p. 93

## CHRONOLOGY OF A TYPICAL WORKER'S COMPENSATION CASE

### Objectives:

- Define an authorized treating physician.
- Discuss the procedure for determining physical restrictions and work status.
- Identify the four events that result in discontinuation of temporary disability payments.
- Define Maximum Medical Improvement.
- Define impairment and describe the difference between impairment and disability.
- Explain the process for obtaining an impairment rating when the authorized treating physician is not Level II accredited.

## CHRONOLOGY OF A TYPICAL WORKER'S COMPENSATION CASE

### Reference to Rule, Statute, Etc.

**Injury occurs at work or worker recognizes symptom of illness which may be work-related**

§8-41-301, C.R.S.



**Worker reports incident symptoms to employer**

§8-43-102(1)(a)  
and (2), C.R.S.



**Employer files a First Report of Injury form with insurance carrier**

If employer does not concur that a work-related injury or disease exists and refuses to file a First Report form, the worker can file a Worker's Claim for Compensation directly with the Division of Workers' Compensation.

§8-43-103(1), C.R.S.



**Worker must seek care with the provider designated by the employer.**

The employer has the right in the first instance to select the authorized treating physician. The claimant is presented with a list of at least four physicians, four clinics, or combination thereof, from which the worker must choose a primary treating physician. If the employer does not timely designate a list of at least four providers when the worker reports an injury, then the worker may see the physician of his/her choice. The physician whom the employee sees on the first visit becomes the authorized provider and remains the authorized provider unless the insurer and patient agree to change providers, the worker exercises an option for one unchallenged change of treating physician, or a judge orders a change in provider. Note that the provider is physician-specific. A provider is not a clinic or organization. Chiropractors must be Level I accredited to treat cases with three or more lost work days or to provide more than 12 treatments or to provide treatment exceeding 90 days.

§8-43-404, C.R.S. and  
§8-42-101(1)(a);  
(3)(a) (III); (3.6),  
C.R.S.



## Responsibilities of a physician at the first visit

1. Take a complete history including job duties, details regarding accident or hazardous exposure and related symptoms, additional past medical history, and history of non-occupational activities.
2. Perform a complete physical examination for all relevant body parts based on the history and patient complaints.
3. Render a diagnosis based on the above.
4. Determine whether the medical probability (greater than 50% likelihood) that the patient's condition is work related. (Causation will be explored in detail in the following chapter.)
5. If it is determined that the patient's condition is not work-related, explain to the patient that the employer is not liable for the cost of the care under workers' compensation. Care must continue under their general health care provide. If you find the condition to be work-related, continue your treatment plan.
6. Order appropriate diagnostic studies and initial treatment (refer to relevant Colorado Division of Workers' Compensation Medical Treatment Guidelines).
7. Determine work and activity restrictions.

If the patient has any restrictions of normal activities of daily living (ADLs) or restrictions for specific job tasks, these restrictions must be clearly described. Examples would be:

- ❖ Occasional lifting up to 20 pounds
- ❖ Frequent lifting limited to 5 pounds
- ❖ No over-head work
- ❖ Sitting limited to 20 minutes followed by a change in position

NEVER order "Modified duty," "desk duty," "light duty," etc. Supervisors differ greatly in their interpretation of these terms.

- Give a copy of work restrictions to the patient and ensure that the supervisor receives a copy.
- Respond timely to requests for verification of a claimant's work status. The statute allows the employer to withhold payments to a medical provider until such information is provided.



Rules of Procedure,  
Rule 17

§8-42-105 & 106,  
C.R.S.

§8-42-105(2)(d), C.R.S.

If the worker is totally restricted from duty, or if the employer cannot provide suitable accommodated duty, he is compensated 66.6% of his wages to a maximum of 91% of the state average weekly wage (“**TTD**” or **Temporary Total Disability**). If the employer allows the worker to return to part-time duty, he is compensated for the remainder of the time in which he cannot work 66.6% of his wages to a maximum of 91% of the state average weekly wage (“**TPD**” or **Temporary Partial Disability**).

§8-42-105(1), C.R.S.

Temporary total disability payments cease when the patient returns to modified or full duty, or if the attending physician releases the patient to modified duty, the employer offers the modified duty and the patient does not comply.

§8-42-106(1), C.R.S.

Designated authorized treating physician completes and signs the WC-164 form (“Physician’s Report of WC Injury”), submit to the payer within 14 days of the date of service, and supply a copy to the patient. If completed by a non-physician provider (e.g. physician’s assistant or advanced practice nurse) there must be a co-signature of the authorized treating physician.

§8-42-105(3), C.R.S.

Rule 16-7(E)



### Follow-up patient visits

1. Continue diagnostic tests and treatment as necessary.

Be sure to follow the Division of Workers’ Compensation Medical Treatment Guidelines. If the DOWC Guidelines must be exceeded, or treatment the patient requires is not covered in the Guidelines, pre-authorization must be sought from the insurance carrier. Carriers are only required to pay for care that is reasonable and medically necessary.

Rules of Procedure,  
Rule 16-9(A)  
Also see Rule 17  
for Treatment  
Guidelines

The insurer will not cover treatment of conditions not associated with the work-related illness or injury. If a new diagnosis results secondary to the treatment or complications of the primary diagnosis, this must be explained in your records for treatment to be covered.

2. Return the patient to full duty or specific activity restrictions as appropriate for current functional status. This activity is essential to the treatment for any patient.

3. Supply a WC164 Report (“Physician’s Report of WC Injury”) or copies of your medical records when submitting bills to the insurer. A copy of the WC164 must also be supplied to the patient or his/her legal representative.

Rules of Procedure,  
Rule 16-7(E)



## Determination of Maximum Medical Improvement (MMI)

Maximum medical improvement exists when the underlying condition causing the disability has become stable and no further treatment is reasonably expected to improve the condition. MMI does not preclude medical maintenance or alteration of the medical condition with the passage of time.

§8-40-201(11.5),  
C.R.S.

Temporary total disability payments will cease at MMI.

(“Grover Meds”);  
Grover v. Industrial  
Commission, 759 P.2d  
705 (Colo. 1988)

Continuing treatment to sustain the patient’s current level of functioning can be maintained but must be documented by the physician in the final report.



## Patient at MMI

Authorized treating physician (generally the primary designated physician) completes and signs the WC-164 form (“Physician’s Report of Workers’ Compensation Injury”) and submits to insurer and patient. If completed by a non-physician provider (e.g. physician’s assistant or advanced practice nurse) there must be a co-signature of the authorized treating physician.

Rules of Procedure,  
Rule 16-7(E)

- ✓ Defines permanent work restrictions or releases to full duty.

If the patient is unable to return to full duty, clearly state permanent physical restrictions. If the worker is unable to return to full duty and the employer cannot accommodate the worker’s permanent restrictions, the worker will not receive any further payment for temporary disability after the date of MMI.

§8-42-105(3)

Determine if no impairment present or if impairment may be present.

An **impairment rating** is used to calculate the final payment of permanent partial disability benefits to the worker. To qualify for an impairment, the worker must have a permanent alteration of a body part or system that affects his activities of daily living. If an impairment exists, refer the worker to a Level II accredited physician within 20 days of declaring MMI. If the treating physician does not refer the patient to a Level II accredited physician within the time period required, the insurer is required to do so within the following 20 days.

§8-42-107(8)(b.5),  
C.R.S.  
Rules of Procedure,  
Rule 12-2

Impairment is determined in Colorado using the *AMA Guides 3<sup>rd</sup> Edition (revised)*. Pursuant to Colorado statute 8-42-101(3.7), C.R.S.: “. . . for purposes of determining levels of medical impairment, the physician shall not render a medical impairment rating based on chronic pain without anatomic or physiologic correlation. Anatomic correlation must be based on objective findings.”

§8-42-101(3.7), C.R.S.  
Rules of Procedure,  
Rule 12-1

- ✓ Patient or insurer may challenge the impairment rating submitted by the authorized treating physician or their consultant. The authorized treating physician’s impairment rating can be challenged by requesting an Independent Medical Examination (IME) agreed-upon by the insurer and the patient, or from the Division of Workers’ Compensation panel of Independent Medical Examiners. The cost for a Division IME is \$675.00.

§8-42-107(8)(b)(II);  
§8-42-107.2, C.R.S.;  
Rules of Procedure,  
Rule 11

## **“To Whom Am I Responsible in the Workers’ Compensation System?”**

### Objectives:

- Review the procedures for release of medical records in workers’ compensation cases.
- Describe medical/ethical issues pertaining to workers’ compensation cases.
- Discuss the role of case management in workers’ compensation.

## TO WHOM AM I RESPONSIBLE IN THE WORKERS' COMPENSATION SYSTEM?

### REFERENCES

<p><b>1. To whom do you owe primary responsibility at all times?</b></p> <ul style="list-style-type: none"> <li>A. The State of Colorado Workers' Compensation System.</li> <li>B. The patient's employer.</li> <li>C. The insurance company whose network you belong to.</li> <li>D. The patient.</li> </ul>	<p>ACOEM Code of Ethics</p>
<p><b>2. What is your current policy for medical record release in the following two situations?</b></p> <p><b>2a.)</b> An insurer requires a copy of your medical records to justify your billing level. Your office:</p> <ul style="list-style-type: none"> <li>A. Copies and sends the complete narrative report</li> <li>B. Sends the physician's complete narrative report if the patient signed a medical record release form for billing purposes.</li> <li>C. Notifies the patient in writing that the physician's complete narrative report will be sent to the insurer.</li> </ul>	<p>Colorado Interprofessional Guidelines</p>
<p><b>2b.)</b> You are treating a patient for a work-related low back injury. In the course of taking the initial history you note that the patient has been treated for depression multiple times in the last ten years and has a 20-year history of schizophrenia. The patient is currently taking medication for the schizophrenia. The employer requests a copy of physician's initial narrative report, which contains this psychiatric history, in order to determine whether they wish to challenge the work-relatedness of his condition. Your office:</p> <ul style="list-style-type: none"> <li>A. Copies and sends the complete narrative report with the physician's initial report.</li> <li>B. Sends the physician's complete narrative report if the patient signed a medical record release form for billing purposes.</li> <li>C. Notifies the patient in writing that the physician's complete narrative report will be sent to the employer.</li> <li>D. Sends the complete narrative report to the employer if the patient has signed a specific release to the employer allowing release of psychological information.</li> </ul>	<p>ACOEM Code of Ethics</p> <p>Chiropractic Standard of Ethics</p> <p>Statute §8-43-404(4)</p>

## REFERENCES

<p><b>3. In a workers' compensation claim, an employer is entitled to which of the following records when no medical record release form has been signed by the patient? Check all that apply.</b></p> <ul style="list-style-type: none"> <li><b>A.</b> Complete medical records including history of past medical illnesses that are unrelated to injury.</li> <li><b>B.</b> Current information regarding diagnosis, detailed treatment plans and names of consultants.</li> <li><b>C.</b> Information in the medical record directly related to the workers' compensation claim.</li> <li><b>D.</b> Work restrictions and time off work information.</li> </ul>	<p>ACOEM Code of Ethics</p> <p>Statutes §8-47-203(1) §8-43-404(4)</p>
<p><b><i>In general, if your office is abiding by current medical record release laws the same procedures can be followed in workers' compensation.</i></b></p>	
<p><b>4. Practical problems with confidential communications.</b></p> <p><b>4a.)</b> You have been the patient's non-workers' comp chiropractor. She is now referred to you for workers' compensation care. She suffered a back injury at work. Should prior, non-work related low back treatment records be automatically provided to the workers' compensation carrier?</p> <ul style="list-style-type: none"> <li><b>A. Yes</b></li> <li><b>B. NO</b></li> </ul>	<p>ACOEM Code of Ethics</p> <p>Statute §8-47-203(1) §8-43-404(4)</p>
<p><b>4b.)</b> An independent nurse case manager hired by your patient's workers' compensation insurer contacts you by phone. The patient is represented by an attorney. You are asked to discuss the patient's current work status including restrictions, compliance with the current treatment plan, and any abnormal pain behaviors you have observed while examining the patient. You should (check all that apply)</p> <ul style="list-style-type: none"> <li><b>A.</b> Discuss all of the above topics with the nurse case manager because the workers' compensation statute waives any protection.</li> <li><b>B.</b> Limit the discussion to work restrictions and place a note in the patient's chart.</li> <li><b>C.</b> Talk to the patient before having any discussion with the case manager.</li> <li><b>D.</b> Do not discuss any topics with the nurse case manager because you have no release from the patient.\</li> <li><b>E.</b> Do not discuss the case because the patient is represented by an attorney.</li> </ul>	<p>Statutes §8-42-101(3.6)(p)(I)(A) and §8-42-101(3.6)(p)(II)</p> <p>American Chiropractic Association of Code of Ethics</p> <p>Colorado Chiropractic Practice Act §12-33-126, C.R.S.</p> <p>Colorado Board of Chiropractic Examiner Rules and Regulations</p> <p>Statute §25-1-802(1)</p>

## REFERENCES

<p><b>4c.)</b> You have spoken with the patient's work supervisor about</p> <ul style="list-style-type: none"><li><b>A.</b> Document the conversation in your records</li><li><b>B.</b> Do nothing – it is only a conversation about work restrictions.</li><li><b>C.</b> Send a copy to the patient if you send a copy to the insurer for billing purposes</li></ul> <p><b>Note:</b> Telephone 7 days post visit DOWC code – Z0701 \$75/15 minutes or written Special Report if more detailed discussion – DOWC code Z0755 \$81.25/15 minutes</p>	Statute §8-43-404(5)(c)
<p><b>4d.)</b> You perform an independent medical exam on a workers' compensation patient. You should (check all that apply):</p> <ul style="list-style-type: none"><li><b>A.</b> Send the report only to the party that hired you.</li><li><b>B.</b> Send the report to the patient, their attorney, and the workers' compensation insurer or employer.</li><li><b>C.</b> Make a full audio-recording of the examination, but only if the insurer or employer is requesting the IME.</li></ul>	Statute §8-43-404(2)  Rule 8-8 et seq.

## **Determining Causality in Workers' Compensation**

Objectives:

- Define an authorized treating physician.
- List the principles of risk assessment used to determine causality and apply them to a case.

# DETERMINING CAUSALITY IN WORKERS' COMPENSATION

## Risk-Assessment or Causal Relationships in everyday life

Wearing a seat belt.

Wearing a helmet for bike riding, motorcycles, skiing, horseback riding.

## Causality Assessment in Medicine

Case #1 55 year old overweight male with HTN presents with severe back pain.

Case #2 25 year old female presents with severe low back pain.

Differential diagnosis

Case #1 abdominal aneurysm

Case #2 pelvic pathology

## Workers' Compensation Causality

- Alleged relationship between the diagnosis and the work-related exposure.
- Estimate of the risk of developing the diagnosis from the actual work exposure.
- If the relationship has a greater than 50% probability then it is medically probable.

## Causation Assessment

1. Record an occupational medical history including a detailed description of the incident reportedly causing the injury or a complete job description of all activities which could have contributed to the patient's symptoms. The description of job duties should include a list of physical activities required, the duration and frequency of these activities and the total time the individual has worked in the job position. At a minimum, the job activities description should consider specific hand tool use, driving or other skilled activities, approximate lifting estimations, description of the posture required in order to complete the job tasks and consideration of the force necessary for the job tasks.
2. Take a complete medical history including medical diseases past and present, and non-occupational activities which could have affected the complaint. Include hobbies involving the hands for upper extremity complaints and weekend sports activities for musculoskeletal injuries.

3. Establish a differential diagnosis for the patient using the complete history, physical exam findings, and the results of any preliminary diagnostic testing.
4. Assess the medical probability of the relationship between the assumed diagnosis and the work-related exposure.

### **Case Examples**

#1 Mesothelioma in a navy veteran who worked on ships in World War II.

Diagnosis is uniformly associated with asbestos exposure.

Asbestos exposure was common in this occupation.

#2 A worker slips on ice while delivering equipment and complains of medial knee pain.

Diagnosis possible medial collateral ligament strain.

Mechanism of injury – employee is not sure.

#3 Secretary develops carpal tunnel.

### **Risk Assessment Method**

To assess causality you must apply traditional risk assessment techniques developed by Bradford-Hill.

1. Strength of the association: The study should show a significant relative risk for developing the disease in question when populations are exposed at a specific exposure level.
2. Consistency of the evidence: Studies with different populations exposed to similar work exposures should produce the same result.
3. Specificity of the result: Studies should be sufficiently controlled to prove that the exposure was the cause of the diagnosis, rather than other confounding exposures or disease entities.
4. Temporal Relationship: The timing of the study and follow-up investigation of the workers should be sufficient to identify the disease in question. Long latency disease studies should exclude those cases occurring too early to be related to the exposure identified in the study.

5. Biological gradient: Studies should show that the greater the exposure, the greater the likelihood of a particular disease or injury. In some cases the phenomenon is “all or none” and no gradient can be present.
6. Coherence: The proposed exposure should be biologically plausible and consistent with previous research. Naturally when an entirely new causal relationship is discovered, initial reports will not necessarily conform with previous literature on the subject.

## **Workers’ Compensation Statutes**

Work related exposure must be the “proximate cause” of the disease or injury.

Proximate cause is defined in Black’s Law Dictionary as the last act “contributory to an injury, without which such injury would not have resulted. The dominant, moving or producing cause.”

## **Pre-Existing Medical Condition**

A pre-existing medical condition which may pre-dispose the worker to an injury does not necessarily mean the case is not work-related. If the worker would not have the injury **without** the work-related event, the injury is most likely also work-related.

Egg shell skull case in legal theory.

Case example – Patient with a partial meniscus tear is hit in the leg with heavy equipment and falls, suffering a full thickness meniscus tear.

Physicians should discuss the impact of pre-existing disease or injury on the current work related condition.

## **Using Risk Assessment**

Case example – A worker is exposed to levels of formaldehyde below the OSHA permitted limits.

1. The worker claims to have irritant-induced reactive airway disease.
2. The worker claims the formaldehyde aggravated his pre-existing asthma.

How would you prove or disprove these assertions?

Always answer this question: “Without the work-related exposure or accident, is it medically probable that the patient would have the current diagnosis and require treatment?”

## **Activities of Daily Living**

Generally, if a worker is performing an activity he would normally be expected to perform in day-to-day tasks at home the injury will not be work-related.

Case – An executive suffers a heart attack while reviewing his routine, office e-mail.

## **Isolated Mental Impairment (no physical injury)**

Pursuant to C.R.S. §8-41-301(2)(a), mental impairment:

“ . . . means a recognized, permanent disability arising from an accidental injury arising out of and in the course of employment when the accidental injury involves no physical injury and consists of a psychologically traumatic event that is generally outside of a workers’ usual experience and would evoke significant symptoms of distress in a worker in similar circumstances. A mental impairment shall not be considered to arise out of and in the course of employment if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, promotion, termination, retirement, or similar action taken in good faith by the employer.”

Remember the final determination of work-relatedness rests with the judicial system. This allows consideration of course and scope of duties, enforced safety standards, and location of injury.

Your medical diagnosis and causality discussion is essential to a work-related case.

<b>STEPS IN CAUSALITY DETERMINATION</b>	
1.	<b>Establish diagnosis (or differential diagnosis if further testing required)</b>
2.	<b>Define Injury or Exposure</b>  For Exposures include <ul style="list-style-type: none"> <li>❖ Length of exposure</li> <li>❖ Level of exposure (actual lifting required, amount of repetitive motion, special tool use, etc.)</li> <li>❖ Comparison of workers' exposure to that of the normal population</li> </ul>
3.	<b>Discuss Intervening Factors</b>  Concurrent non-work-related injuries or disease processes, pre-existing impairment, or disease related activities outside of work, sports, hobbies, etc.
4.	<b>Explain any scientific evidence supporting a cause and effect relationship between the diagnosis and the exposure or injury</b>
5.	<b>Assign a medical probability level to the case in question</b>  <ul style="list-style-type: none"> <li>❖ Medically probable &gt; 50% likely</li> <li>❖ Medically possible ≤ 50% likely</li> </ul>

The following pages and tables are reproduced from the Division's *Cumulative Trauma Conditions* medical treatment guideline, eff. October 30, 2010. This information should be used for assessment of causality and diagnoses of disorders involving especially but not exclusively disorders of the upper extremity. The "**Algorithmic Steps for Causation Assessment**" flow-chart applies to causation assessment in general.

## Physical Examination Findings Reference Table

Section F.		Specific Musculoskeletal Diagnosis
DIAGNOSIS	SYMPTOMS	SIGNS (Required Findings)
Aggravated Osteoarthritis of the Wrist.	Pain usually in the carpal-metacarpal joints; or in metacarpal-phalangeal joints.	<p><u>At least one of the following:</u></p> <ul style="list-style-type: none"> <li>• Positive grind test resulting in pain; crepitus;</li> <li>• Subluxation of the metacarpal may be induced in advanced cases;</li> <li>• Swelling;</li> <li>• Reduced motion;</li> <li>• Angular deformities;</li> <li>• Tenderness with palpation of thumb phalangeal-metacarpal or carpal- metacarpal joint.</li> </ul>
de Quervain's Disease	Tenderness over the first dorsal extensor compartment(anatomical snuff box).	<p><u>At least one of the following:</u></p> <ul style="list-style-type: none"> <li>• Pain worsened by resisted thumb abduction and/or extension with or without resistance;</li> <li>• Positive Finkelstein's test.</li> </ul>
Epicondylitis-Lateral (Epicondylalgia)	Elbow pain over the lateral epicondyle increased with gripping.	<p>Tenderness to palpation at/near lateral epicondyle and pain over the lateral epicondyle and/or extensor mass of the forearm with one of the following maneuvers:</p> <ul style="list-style-type: none"> <li>• Active or resisted wrist extension;</li> <li>• Active or resisted middle finger extension;</li> <li>• Active or resisted supination.</li> </ul>
Epicondylitis-Medial (Epicondylalgia)	Elbow pain over the medial epicondyle.	<p>Tenderness to palpation at/near medial epicondyle and pain over the medial epicondyle and/or flexor mass of the forearm with one of the following maneuvers:</p> <ul style="list-style-type: none"> <li>• Active or resisted wrist flexion;</li> <li>• Active or resisted pronation.</li> </ul>
Extensor Tendon	Pain localized to the affected tendon(s) worsened by wrist or	Pain and/or tenderness with active or resisted wrist/digit extension,

Section F.	Specific Musculoskeletal Diagnosis	
Disorders of the Wrist	finger extension.	specific to the extensor mechanism involved.
Flexor Tendon Disorders of the Wrist	Pain/tenderness localized to affected tendons.	Reproduction of pain with active or resisted wrist/digit flexion or ulnar deviation specific to the flexor mechanism involved.
Triangular Fibrocartilage Complex Tear (TFCC)	Symptoms mainly on ulnar side of the wrist.	<p>Tenderness over the TFCC complex and localized pain, clicking, or findings of abnormal motion with one of the following movements:</p> <ul style="list-style-type: none"> <li>• Forced supination and pronation with axial pressure on an ulnar deviated wrist;</li> <li>• The patient pushes up from a seating position using the hand, and/or</li> <li>• Ballottement of the distal ulna with the wrist supinated causes abnormal motion as compared to the asymptomatic side.</li> </ul>
Trigger Finger	Difficulty flexing the finger with a catching or triggering sensation.	<p>One of the following:</p> <ul style="list-style-type: none"> <li>• Tenderness at the A-1 pulley with finger flexion;</li> <li>• Triggering of the digit;</li> <li>• Difficulty flexing and extending the finger with a palpable nodule.</li> </ul>

**Physical Exam Findings Reference (continued):**

Section G	Specific Peripheral Nerve Diagnosis	
DIAGNOSIS	SYMPTOMS	SIGNS (Required Findings)
Carpal Tunnel Syndrome	<ul style="list-style-type: none"> <li>• Specific paresthesias in 2 of the following digits: thumb, index, and middle finger.</li> <li>• Shaking of the hand (to relieve symptoms) and nocturnal symptoms are common.</li> </ul>	<p>At least one of the following:</p> <ul style="list-style-type: none"> <li>• Positive Phalen’s sign;</li> <li>• Positive Tinel’s sign over the carpal tunnel;</li> <li>• Positive closed fist test;</li> <li>• Positive compression test;</li> <li>• Thenar atrophy may be present later in course;</li> <li>• Weakness of abductor pollicis brevis;</li> <li>• Sensory loss to pinprick, light touch, two-point discrimination or Semmes-Weinstein monofilament tests in a median nerve distribution.</li> </ul>
Cubital Tunnel Syndrome	<p>Paresthesias or dull, aching sensations in the 4<sup>th</sup> and 5<sup>th</sup> digits (ring and small fingers) and discomfort near the medial aspect of the elbow.</p>	<p>Paresthesias or dull, aching in the 4<sup>th</sup> and 5<sup>th</sup> digits and at least one of the following exam findings:</p> <ul style="list-style-type: none"> <li>• Diminished sensation of the fifth and ulnar half of the ring fingers, which may sometimes include sensory loss to pinprick, light touch, two-point discrimination or Semmes-Weinstein monofilament tests in an ulnar nerve distribution;</li> <li>• Positive elbow flexion/ulnar compression test;</li> <li>• Later stages manifested by: intrinsic atrophy and ulnar innervated intrinsic weakness; Wartenberg’s sign; Froment’s sign.</li> </ul>

Section G	Specific Peripheral Nerve Diagnosis	
Guyon Canal (Tunnel) Syndrome	Paresthesias in the 4 <sup>th</sup> and 5 <sup>th</sup> digits (ring and small fingers) without proximal ulnar complaints.	At least one of the following exam findings: <ul style="list-style-type: none"> <li>• Positive Tinel's at hook of hamate;</li> <li>• Numbness or paresthesias of the palmer surface of the ring and small fingers;</li> <li>• Decreased strength of the adductor pollicis, abductor digiti minimi, and/or lumbricals.</li> </ul>
Posterior Interosseous Nerve Entrapment (PIN)	Weakness of finger and thumb extension	Weakness or inability to extend fingers or thumb;
Pronator Syndrome	Pain/paresthesias in the median nerve distribution distal to the elbow.	Paresthesias in the median nerve distribution and at least one of the following reproduces median nerve symptoms: <ul style="list-style-type: none"> <li>• Resisted pronation with elbow flexed at 90 degrees or elbow extended;</li> <li>• Positive Tinel's at the proximal edge of the pronator teres muscle over the median nerve.</li> </ul>
Radial Tunnel Syndrome	Pain over the lateral posterior forearm. May occur in conjunction with and must be distinguished from lateral epicondylitis. May include paresthesias over the dorsal radial hand and wrist.	The following two elements are required: <ul style="list-style-type: none"> <li>• Tenderness over the radial nerve near the proximal edge of the supinator muscle;</li> <li>• Resisted supination or resisted middle finger extension with the forearm pronated and extended reproduces symptoms.</li> </ul>

3. **MEDICAL CAUSATION ASSESSMENT FOR CUMULATIVE TRAUMA CONDITIONS** (ref. CTC Treatment Guideline)

**General Principles of Causation Assessment**

The clinician must determine if it is medically probable (greater than 50% likely or more likely than not) that the need for treatment in a case is due to a work-related exposure or injury. Treatment for a work-related condition is covered when: 1) the work exposure causes a new condition; or 2) the work exposure causes the activation of a previously asymptomatic or latent medical condition; or 3) the work exposure combines with, accelerates, or aggravates a pre-existing symptomatic condition. In legal terms, the question that should be answered is: "Is it medically probable that the patient would need the treatment that the clinician is recommending if the work exposure had not taken place?" If the answer is "yes," then the condition is not work-related. If the answer is "no," then the condition is most likely work-related. In some cases, the clinician may need to order diagnostic testing or jobsite evaluations to make a judgment on medical probability. The following steps should be used to evaluate causality in CTC cases:

- Step 1:** Make a specific and supportable diagnosis. Remember that cumulative trauma, repetitive strain and repetitive motion are not diagnoses. Examples of appropriate diagnoses include: specific tendonopathies, strains, sprains, and mono-neuropathies. Refer to Sections F (Specific Musculoskeletal Disorders) and G (Specific Peripheral Nerve Disorders) for the specific findings of common CTCs.
- Step 2:** Determine whether the disorder is known to be or is plausibly associated with work. The identification of work-related risk factors is largely based on comparison of risk factors (as described in Section D.3. a. & b. Foundations for Evidence of Occupational Relationships and Using Risk Factors to Determine Causation) with the patient's work tasks.
- Step 3:** Interview the patient to find out whether risk factors are present in sufficient degree and duration to cause or aggravate the condition. Consider any recent change in the frequency or intensity of occupational or non-occupational tasks. In some cases, a formal jobsite evaluation may be necessary to quantify the actual ergonomic risks. Refer to the Jobsite Evaluation Section E.6.c.
- Step 4:** Complete the required match between the risk factors identified on the Risk Factor Table and the established diagnosis using the system described in Section D. 3. b.
- Step 5:** Determine whether a temporal association exists between the workplace risk factors and the onset or aggravation of symptoms.
- Step 6:** Identify non-occupational diagnoses, such as rheumatoid arthritis, obesity, diabetes, as well as avocational activities, such as golf and tennis. This information infrequently affects the work-related causation decision. It may be applicable when exposure levels are low and the case does not meet evidence-based criteria.

**a. Foundations for Evidence of Occupational Relationships:** All results described in this section are a result of a thorough review of the epidemiologic literature available at the time of this guideline. The studies most heavily relied upon healthy worker populations with a variety of exposures, not all of which were well-described quantitatively. No single epidemiologic study fulfills all criteria for causality. The clinician must recognize that currently available epidemiologic data is based on population results. Individual variability lies outside the scope of these studies and must be addressed by the physician on a case-by-case basis. The clinician is responsible for documenting specific information regarding the force, posture, repetition, and other risk factors as listed in the table entitled "Risk Factors Definitions." Job title alone is not sufficient to determine the risk factors. A jobsite evaluation is usually necessary.

Many studies have been completed in industrial setting focusing on cumulative trauma conditions or upper extremity complaints in relationship to work exposures. The studies vary in several ways that directly affect the interpretation of their results. Studies with 1) an accepted clinical exam confirming the diagnosis

and 2) work exposures validated by direct observation, or questionnaires that were correlated with direct observation, provide the strongest evidence. Well-done, prospective, longitudinal studies (cohort studies) are preferred; however for uncommon disorders, these studies may not be able to identify the causal factors. We considered other large prevalence and incidence studies when minimum quality criteria had been met and the self-reported exposure uses reliable questionnaires.

Many studies report symptoms rather than disease conditions. These studies are useful for ergonomic research or as pilot studies but do not directly affect the evidence level for causation. They are mentioned, when useful, as indirect evidence. If multiple well-done symptom studies show no increase in symptomatology with specific activities, it follows that there is very little change that the studied exposure causes disease.

In addition, there are a few studies which address less common musculoskeletal diagnoses or peripheral nerve conditions other than carpal tunnel syndrome, such as posterior interosseus nerve entrapment and pronator syndrome. In these cases, we rely upon studies which report the risks for related conditions.

Many of the original studies identifying diagnosable cumulative trauma conditions were performed in manufacturing industries and meat, fish and poultry processing companies. In these industries most workers are exposed to highly repetitive mono-task jobs which frequently involve a forceful grip, awkward postures, vibration, and cold environments. The evidence for increased disorders when these multiple risk factors are present is compelling. Research attempting to define clear, threshold exposure limits for increased risk from isolated tasks and/or intermittent exposures has less consistent results.

The quality of keyboarding studies is highly variable. Most of the studies rely on self report. Self report appears to approximately double the actual time spent using the keyboard. Some studies show distortion highest in the medium range of use. There appears to be less inflation for self reported mouse use. Fortunately a few studies have provided more objective keyboard use data.

The group of studies now available provides good evidence that keyboarding in a reasonable ergonomic posture (wrist with 30 degrees or less of extension and 15 degrees or less of radial deviation) up to 7 hours per day under usual conditions is very unlikely to cause carpal tunnel syndrome or other upper extremity disorders. This is based on studies of carpal tunnel pressure under a variety of typing and wrist positions as well as a number of studies of workers who keyboard on a regular basis. Clinicians may determine in a particular case that there is a relationship based on the ergonomic conditions or on excessive typing, such as more than 7 hours per day of essentially uninterrupted keyboard use per day or full-day court reporting.

There is some evidence that mouse use appears to be associated with carpal tunnel syndrome and related symptoms with 4 hours or greater per day of continuous use. Studies of pressure within the carpal tunnel indicated that pressures may rise to levels which could affect the median nerve when the mouse is being dragged or clicked. Again the actual ergonomics of the work place should be considered for each individual patient before making a final causation decision.

There was a large variety in assessment strategies for lower quality studies. Examples included: symptom only reports; dichotomous choices for exposures, e.g. 1 hour or less per week repetitive activities versus more than 1 hour per week; self report data that does not follow basic pathophysiology, e.g. mouse use between 2.5 & 5 hours per week causing wrist pain; and bias introduced due to prior knowledge of the participants regarding expected work & symptom correlations. In order to reasonably integrate the volume of disparate data, interpretation of lower quality studies took into account reasonable pathophysiology and exposure limits. Dose response relationships were also examined to look for trends in exposure which resulted in increased disease or symptoms.

Most studies were unable to truly assess repetition alone, unassociated with other risk factors. Indirect evidence from a number of studies supports the conclusion that task repetition up to 6 hours per day unaccompanied by other risk factors is not causally associated with cumulative

trauma conditions. Risk factors that are likely to be associated with specific CTC diagnostic categories include: extreme wrist or elbow postures; force including regular work with hand tools greater than 1 kg or tasks requiring greater than 50% of an individual's voluntary maximal strength; work with vibratory tools at least 2 hours per day; or cold environments.

The variability in study design presented a challenge for creating physiologically reasonable hour limits for the specific primary and secondary risk factors. We chose the strongest studies for the specific risks involved and extrapolated the measures utilizing the number of quartiles in the working day the person was exposed, or the exposure groups themselves. For example,  $\frac{3}{4}$  of a day exposure was translated to a 6 hour exposure and exposure groups working on assembly lines or in similar employment were also assumed to be performing the same tasks for at least 6 hours per day. This cut-off corresponds the best to studies which found positive diagnoses in workers performing repetitive jobs with at least one other risk factor. These constitute our primary risk factor definitions. For the secondary risk factor definitions one study provided direct evidence of 4 hours for the most common risks. We also found indirect evidence from other studies, such as one assessing upper extremity functional impairment and another determining the presence of upper extremity symptoms that 4 hours was a reasonable cut off point for determining physiologically acceptable secondary risks.

No studies examined the relationship between the development of ganglion cysts and work activities; however, work activities, such as bending or twisting of the wrist repetitively, may cause an aggravation of existing ganglion cysts that interferes with function.

Aggravation of a pre-existing medically established diagnosis must be determined on an individual case basis. A comparison of the worker's specific job duties with usual activities of daily living and the occupational risk factors should contribute to the discussion.

#### Non-occupational exposures

Most studies demonstrate an association of cumulative trauma conditions with older age; high BMI; the presence of other upper extremity musculoskeletal diagnoses; related diseases such as auto-immune conditions, diabetes, hypothyroidism and rheumatologic diseases; and psychosocial issues including relationships with supervisors. The influence of these non-occupational risk factors varies according to the specific diagnoses involved. While the presence of any of these additional factors may be viewed as contributing to the disorder in question, that does not refute the actual evidence from the defined risk factors supporting a specific work related condition.

Use the Risk Factor Definition and Diagnosis Based Risk Factors tables with the following direction to formulate the causation of diagnoses established as cumulative trauma conditions.

#### **b. Using Risk Factors to Determine Causation (Directions):**

The physician should perform the following:

##### **Step 1. Determine the diagnosis.**

Using the history, physical examination and supporting studies, a medical diagnosis must be established. Refer to Section F (Specific Musculoskeletal Disorders and G (Specific Peripheral Nerve Disorders).

##### **Step 2. Clearly define the job duties of the worker.**

Do not rely solely on the employer's description of job duties. The worker's description of how they actually perform the duties is extremely important. Jobsite evaluations are always appropriate, but are sometimes

unnecessary when the physician can identify the job duty which appears to be causing the symptoms and provide a method for ergonomically correcting the activity.

**Step 3. Compare the worker's duties with the Primary Risk Factor Definition Table.**

Hours are calculated by adding the total number of hours per day during which the worker is exposed to the defined risk. Breaks, time performing other activities and inactive time are not included in the total time. When the employee meets the definition for a sole Primary Risk Factor and the risk factor is physiologically related to the diagnosis, it is likely that the worker will meet causation for the cumulative trauma condition. When the Primary Risk Factor identified is not physiologically related to the diagnosis, causation will not be established at this point and Step 4 needs to be considered.

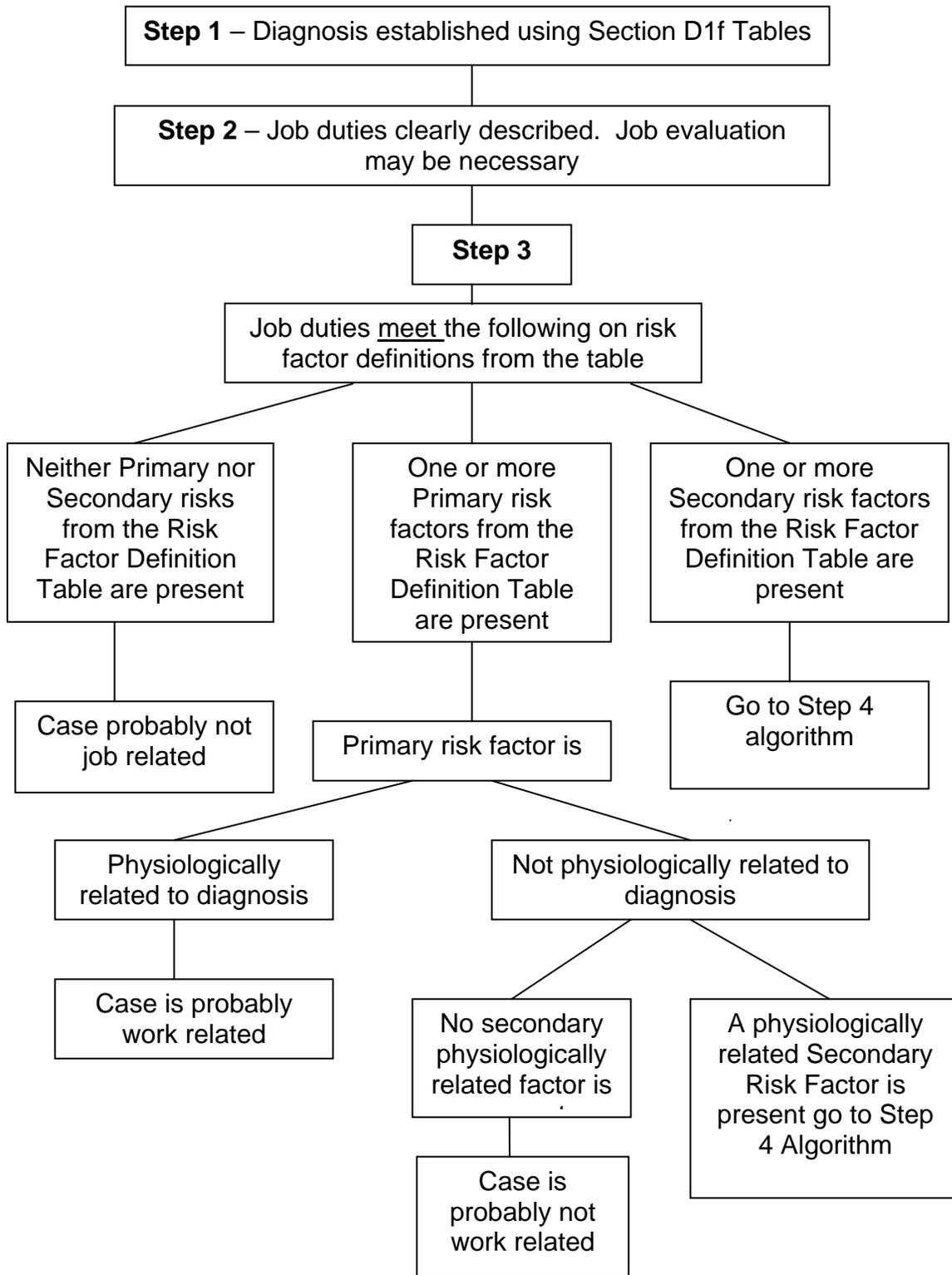
**Step 4. Compare the worker's risk factors identified in Step 2 with the Secondary Risk Factor definitions on the Risk Factor Definition Table. If secondary risk factors are identified proceed to the Diagnosis Based Risk Factor Table.**

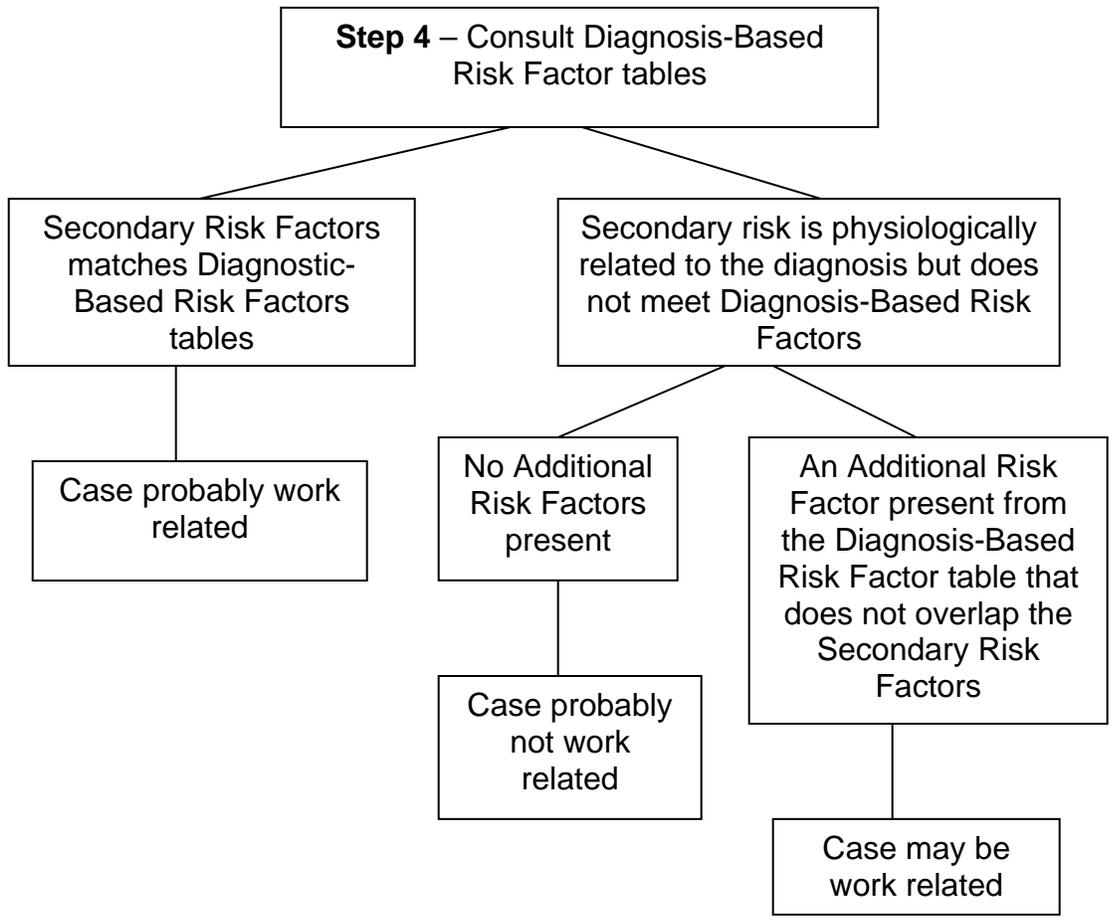
When no Primary Risk Factors are present but one or more Secondary Risk Factors are found on the Risk Factor Definitions Table proceed to the Diagnosis Based Risk Factor Table. Elements in this table are listed under the strength of evidence headings. This includes a category for strength of evidence for risks that have been demonstrated not to be related to the diagnosis. Consult the diagnostic category pertaining to the worker. For a number of less common diagnoses, little direct research has been done that meets our quality standards. Therefore, the risk factors for these diagnoses use the risk factors from physiologically related, better researched diagnostic titles. Initially, check the evidence statements for or against causation based on the secondary risks identified previously. If the Diagnosis Based Risk Factor table establishes a match between the Secondary Risk Factor(s) and other job duties, using the evidence based columns for the established diagnosis, the case is likely work-related based on evidence. If none of the evidence categories matches the worker, causation based solely on evidence from research has not been established.

**Step 5.** If an evidence based causation relationship, based on Steps 1-4, has not been established and the worker has one Secondary Risk Factor from the Risk Definition table, the physician may consult the last column of the Diagnosis Based Risk Factor table entitled "Additional Risk Factors." This category describes medically accepted physiologic risk factors for the diagnosis and risk factors which demonstrated an association with the diagnosis in lower quality studies that did not meet our standards of evidence. Some of the additional risk factors have less clear definitions due to lack of definition in the lower quality studies. These risk factors were added only when the medical consensus of the multi-disciplinary group agreed they were physiologically plausible. When a Secondary Risk Factor has been identified that does not meet the evidence based definitions in the Diagnosis Based Risk Factor Tables, physicians may use the other "Additional Risk Factors", as appropriate, to establish the presence of combined risk factors and establish causation. The worker must have met at least one of the Secondary Risk Factor definitions from

the Risk Factor Definition table and that risk factor must be physiologically related to the diagnosis, in order to use the “Additional Risk Factors” in the Diagnosis Based Risk Factor table. Additional Risk factors that duplicate the conditions in the Secondary Risk Factor identified for the case may not be used. Any conclusions using this methodology are not strictly evidence-based and therefore the physician should include a discussion of why the Additional Risk Factors are pertinent in the particular case.

## Algorithmic Steps for Causation Assessment





/

## RISK FACTOR DEFINITIONS

*CAUSATION MAY BE ESTABLISHED BY THE PRESENCE OF 1) A DIAGNOSIS-RELATED SOLE PRIMARY RISK FACTOR WHICH IS PHYSIOLOGICALLY RELATED TO THE DIAGNOSIS OR; 2) AT LEAST ONE SECONDARY RISK FACTOR THAT MEETS THE REQUIREMENTS FROM THE DIAGNOSIS-BASED RISK FACTOR TABLE*

NOTE: Hours are calculated by totaling the cumulative exposure time to the risk over an 8 hour day. Breaks or periods of inactivity or performing other types of work tasks are not included.

Category	As a Primary Risk Factor	Secondary Risk Factor
<b><u>Force and Repetition/Duration</u></b>	6 hrs. of: > 50% of individual maximum force with task cycles 30 seconds or less or force is used for at least 50% of a task cycle-maximum force for most individuals is 3-5 kg of force.	4 hrs. of: > 50% of individual maximum force with task cycles 30 seconds or less or force is used for at least 50% of a task cycle-maximum force for most individuals is 3-5 kg of force.
	6 hrs. of: lifting 10 lbs > 60x per hour.	4 hrs. of: lifting 10 lbs > 60x per hour. *
	6 hrs. of: use of hand held tools weighing 2 lbs or greater.	4 hrs. of: use of hand held tools weighing 2 lbs or greater.
<b><u>Awkward Posture and Repetition/Duration</u></b>	4 hrs. of: Wrist flexion > 45 degrees, extension > 30 degrees, or ulnar deviation > 20 degrees.	
	6 hrs. of: Elbow - flexion > 90 degrees.	4 hrs. of: Elbow - flexion > 90 degrees.
	6 hrs. of: Supination/pronation with task cycles 30 seconds or less or posture is used for at least 50% of a task cycle.	4 hrs. of: Supination/pronation with task cycles 30 seconds or less or posture is used for at least 50% of a task cycle.*

## RISK FACTOR DEFINITIONS

*CAUSATION MAY BE ESTABLISHED BY THE PRESENCE OF 1) A DIAGNOSIS-RELATED SOLE PRIMARY RISK FACTOR WHICH IS PHYSIOLOGICALLY RELATED TO THE DIAGNOSIS OR; 2) AT LEAST ONE SECONDARY RISK FACTOR THAT MEETS THE REQUIREMENTS FROM THE DIAGNOSIS-BASED RISK FACTOR TABLE*

**NOTE:** Hours are calculated by totaling the cumulative exposure time to the risk over an 8 hour day. Breaks or periods of inactivity or performing other types of work tasks are not included.

Category	As a Primary Risk Factor	Secondary Risk Factor
<b><u>Computer Work</u></b>	<p><b>Note:</b> Up to 7 hours per day at an ergonomically correct workstation is not a risk factor.</p> <p>&gt; 4 hrs. of: Mouse use.</p>	
<b><u>Use of handheld vibratory power tools and Duration</u></b>	6 hrs. for more common types of vibration exposure.	2 hrs. When accompanied by other risks.
<b><u>Cold Working Environment</u></b>		Ambient temperature of 45F or less for 4 Hrs. or more, such as handling frozen foods that are 10 degrees.

\* Referencing related studies, which established 4 hours as a cut off for symptoms of cumulative trauma conditions and which found 4 hours of exposure to be related to functional problems of the upper extremity, as well as reasonable inferences from physiological knowledge, 4 hours is considered the most reasonable cut off.

## DIAGNOSIS - BASED RISK FACTORS

Hours are calculated by totaling the cumulative exposure time to the risk over an 8 hour day. Breaks or periods of inactivity or performing other types of work tasks are not included. Unless the hours are specifically stated below, "combination" of factors described below uses the Secondary Risk Factor Definitions from the Risk Factor Definition Table

Diagnosis	Evidence FOR Specific Risk Factors			Evidence AGAINST Specific Risk Factors	Non-Evidence-Based Additional Risk Factors to Consider. These factors must be present for at least 4 hours of the work day, and may not overlap evidence risk factors. <sup>1</sup>
	Strong Multiple high quality studies	Good One high quality study or multiple adequate studies	Some One adequate study		
<b><u>Aggravated Osteoarthritis of the Wrist</u></b>	No Quality Evidence Available				Awkward Posture (depending on the joint involved) Repetition of activities affecting the joint involved for 4 hrs. Prior Injury.
<b><u>Carpal Tunnel Syndrome</u></b>		Combination of force, repetition, and vibration.	Wrist bending or awkward posture for 4 hrs.	Good evidence - Keyboarding less than or equal to 7 hrs. in good ergonomic position is NOT RELATED.	High repetition defined as task cycle times of less than 30 seconds or performing the same task for more than 50% of the

## DIAGNOSIS - BASED RISK FACTORS

Hours are calculated by totaling the cumulative exposure time to the risk over an 8 hour day. Breaks or periods of inactivity or performing other types of work tasks are not included. Unless the hours are specifically stated below, “combination” of factors described below uses the Secondary Risk Factor Definitions from the Risk Factor Definition Table

Diagnosis	Evidence FOR Specific Risk Factors			Evidence AGAINST Specific Risk Factors	Non-Evidence-Based Additional Risk Factors to Consider. These factors must be present for at least 4 hours of the work day, and may not overlap evidence risk factors. <sup>1</sup> total cycle time.
	Strong Multiple high quality studies	Good One high quality study or multiple adequate studies	Some One adequate study		
<b><u>Carpal Tunnel Syndrome (continued)</u></b>		Combination of repetition and force for 6 hours.			
		Combination repetition and forceful tool use with awkward posture for 6 hours – Deboning study.	Mouse use more than 4 hours.	Good evidence- Repetition alone less than or equal to 6 hrs. is NOT RELATED.	Tasks using a hand grip.
		Combination force, repetition, and awkward posture.	Combination cold and forceful repetition for 6 hours - Frozen food handling.		Extreme wrist radial/ulnar positions or elbows in awkward postures.

## DIAGNOSIS - BASED RISK FACTORS

Hours are calculated by totaling the cumulative exposure time to the risk over an 8 hour day. Breaks or periods of inactivity or performing other types of work tasks are not included. Unless the hours are specifically stated below, “combination” of factors described below uses the Secondary Risk Factor Definitions from the Risk Factor Definition Table

Diagnosis	Evidence FOR Specific Risk Factors			Evidence AGAINST Specific Risk Factors	Non-Evidence-Based Additional Risk Factors to Consider. These factors must be present for at least 4 hours of the work day, and may not overlap evidence risk factors. <sup>1</sup>
	Strong Multiple high quality studies	Good One high quality study or multiple adequate studies	Some One adequate study		
<b><u>Cubital Tunnel Syndrome</u></b>			Combination forceful tool use, repetition and probably posture for 6 hours - Holding a tool in position with repetition.		Wrist bending and/or full elbow flexion/extension, repetition for 4 hours, vibration. Repetitive pronation of forearm. <sup>3</sup> Sustained pressure at the cubital tunnel.
<b><u>DeQuervain's Disease</u></b>  <b><u>DeQuervain's (cont)</u></b>		Combination force, repetition, & posture.			Wrist in ulnar deviation. <sup>3</sup> Repetitive thumb abduction and extension. <sup>3</sup> Wrist bending in extreme postures. Precise hand motions e.g. dental hygienists. Repetitive hitting.

## DIAGNOSIS - BASED RISK FACTORS

Hours are calculated by totaling the cumulative exposure time to the risk over an 8 hour day. Breaks or periods of inactivity or performing other types of work tasks are not included. Unless the hours are specifically stated below, “combination” of factors described below uses the Secondary Risk Factor Definitions from the Risk Factor Definition Table

Diagnosis	Evidence FOR Specific Risk Factors			Evidence AGAINST Specific Risk Factors	Non-Evidence-Based Additional Risk Factors to Consider. These factors must be present for at least 4 hours of the work day, and may not overlap evidence risk factors. <sup>1</sup>
	Strong Multiple high quality studies	Good One high quality study or multiple adequate studies	Some One adequate study		
<b><u>Epicondylitis Lateral -</u></b>		<p>Combination – awkward posture (forearm supination past 45 degrees) and forceful lifting.</p> <p>Combination force and possible awkward posture – study used repetition and turning and screwing.</p> <p>Combination – force &amp; repetition, force</p>		Some evidence keyboard use is NOT RELATED.	Wrist posture in extension and repetitive supination of the forearm and/or elbow extension. <sup>3</sup>

## DIAGNOSIS - BASED RISK FACTORS

Hours are calculated by totaling the cumulative exposure time to the risk over an 8 hour day. Breaks or periods of inactivity or performing other types of work tasks are not included. Unless the hours are specifically stated below, "combination" of factors described below uses the Secondary Risk Factor Definitions from the Risk Factor Definition Table

Diagnosis	Evidence FOR Specific Risk Factors			Evidence AGAINST Specific Risk Factors	Non-Evidence-Based Additional Risk Factors to Consider. These factors must be present for at least 4 hours of the work day, and may not overlap evidence risk factors. <sup>1</sup>
	Strong Multiple high quality studies	Good One high quality study or multiple adequate studies	Some One adequate study		
		and wrist and hand repetition.			
<b><u>Epicondylitis Lateral (cont)</u></b>			Combination repetition and awkward posture including static posture.		

## DIAGNOSIS - BASED RISK FACTORS

Hours are calculated by totaling the cumulative exposure time to the risk over an 8 hour day. Breaks or periods of inactivity or performing other types of work tasks are not included. Unless the hours are specifically stated below, “combination” of factors described below uses the Secondary Risk Factor Definitions from the Risk Factor Definition Table

Diagnosis	Evidence FOR Specific Risk Factors			Evidence AGAINST Specific Risk Factors	Non-Evidence-Based Additional Risk Factors to Consider. These factors must be present for at least 4 hours of the work day, and may not overlap evidence risk factors. <sup>1</sup>
	Strong Multiple high quality studies	Good One high quality study or multiple adequate studies	Some One adequate study		
<b><u>Epicondylitis Medial</u></b>		Combination - force & repetition, force and wrist and hand repetition.		Some evidence keyboard use is NOT RELATED.	Wrist posture in flex and repetitive pronation and/or elbow extension. <sup>3</sup>
		Combination - forceful exertion and repetition 6 hours.			

## DIAGNOSIS - BASED RISK FACTORS

Hours are calculated by totaling the cumulative exposure time to the risk over an 8 hour day. Breaks or periods of inactivity or performing other types of work tasks are not included. Unless the hours are specifically stated below, “combination” of factors described below uses the Risk Factor Definitions found in the Secondary Risk Factor column.

Diagnosis	Evidence FOR Specific Risk Factors			Evidence AGAINST Specific Risk Factors	Non-Evidence-Based Additional Risk Factors to Consider. These factors must be present for at least 4 hours of the work day, and may not overlap evidence risk factors. <sup>1</sup>
	Strong Multiple high quality studies	Good One high quality study or multiple adequate studies	Some One adequate study		
<u>Extensor tendon disorders of the Wrist</u>		Combination force, repetition, & posture.			Sustained tool use. Awkward posture. <sup>3</sup> No relationship to keyboard use is expected in a good ergonomic workstation. Wrist bending in extreme postures. Repetitive hitting.
<u>Flexor tendon disorders of the Wrist</u>		Combination force, repetition, & posture.			Sustained tool use. Awkward posture. <sup>3</sup> No relationship to keyboard use is expected in a good ergonomic workstation. Wrist bending in extreme postures. Repetitive hitting.
<u>Guyon Canal</u>	No Quality Evidence Available.				Ulnar wrist posture and

## DIAGNOSIS - BASED RISK FACTORS

Hours are calculated by totaling the cumulative exposure time to the risk over an 8 hour day. Breaks or periods of inactivity or performing other types of work tasks are not included. Unless the hours are specifically stated below, “combination” of factors described below uses the Risk Factor Definitions found in the Secondary Risk Factor column.

Diagnosis	Evidence FOR Specific Risk Factors			Evidence AGAINST Specific Risk Factors	Non-Evidence-Based Additional Risk Factors to Consider. These factors must be present for at least 4 hours of the work day, and may not overlap evidence risk factors. <sup>1</sup>
	Strong Multiple high quality studies	Good One high quality study or multiple adequate studies	Some One adequate study		
					flexion. Direct pressure on the wrist.
<b><u>Posterior Interosseus Nerve Entrapment</u></b>	Refer to lateral epicondylitis section above for indirect evidence. No specific evidence available.				
<b><u>Pronator Syndrome</u></b>	Refer to medial epicondylitis section above for indirect evidence. No specific evidence available.				
<b><u>Trigger Finger</u></b>			Hand tool use – 6 hours.		Repeated digital flexion.
<b><u>Radial Tunnel Syndrome</u></b>			Repetition and force - force of 1 kg with cycle time < 1 minute or awkward posture (static posture) elbow > 90 degrees.		Repetitive Supination. Extension of the elbow from 0 to 45 degrees.

## DIAGNOSIS - BASED RISK FACTORS

Hours are calculated by totaling the cumulative exposure time to the risk over an 8 hour day. Breaks or periods of inactivity or performing other types of work tasks are not included. Unless the hours are specifically stated below, “combination” of factors described below uses the Risk Factor Definitions found in the Secondary Risk Factor column.

Diagnosis	Evidence FOR Specific Risk Factors			Evidence AGAINST Specific Risk Factors	Non-Evidence-Based Additional Risk Factors to Consider. These factors must be present for at least 4 hours of the work day, and may not overlap evidence risk factors. <sup>1</sup>
	Strong Multiple high quality studies	Good One high quality study or multiple adequate studies	Some One adequate study		
<b><u>Triangular Fibrocartilage Compression</u></b>	No Quality Evidence Available.				<p>Usually from traumatic hyperextension which may become symptomatic over time.</p> <p>Wrist posture in extension and repetitive supination of the forearm and/or elbow extension.</p> <p>For occupational, usually unilateral with ulnar wrist pain while supinating and extending the wrist as part of the regular work duty.</p>

<sup>1</sup> Physiological risk factors are those generally agreed upon by the medical community to cause the specific condition described. Other risk factors described are those identified in lower quality studies that are possibly related. These are consensus risk factors.

<sup>2</sup> Combined factors refer to the Secondary Risk Factor definitions found in the Risk Factor Definition Table.

<sup>3</sup> **Caution:** These additional risk categories may not be used when awkward posture, using a similar definition, has been

## DIAGNOSIS - BASED RISK FACTORS

Hours are calculated by totaling the cumulative exposure time to the risk over an 8 hour day. Breaks or periods of inactivity or performing other types of work tasks are not included. Unless the hours are specifically stated below, “combination” of factors described below uses the Risk Factor Definitions found in the Secondary Risk Factor column.

Diagnosis	Evidence FOR Specific Risk Factors			Evidence AGAINST Specific Risk Factors	Non-Evidence-Based Additional Risk Factors to Consider. These factors must be present for at least 4 hours of the work day, and may not overlap evidence risk factors. <sup>1</sup>
	Strong Multiple high quality studies	Good One high quality study or multiple adequate studies	Some One adequate study		

cited as a Secondary Risk Factor.

<sup>4</sup> Evidence rated as strong by NIOSH 1997 criteria are placed in the “good” category because the NIOSH strong evidence definition matches the Colorado “good” level of evidence requiring multiple adequate studies.

<sup>5</sup> Due to small case size and a definition of low force/high repetition jobs that likely included many jobs qualifying for a force risk from the “Risk Definitions” table, this study does not support repetition as a sole risk factor.

## **Do I Really Need to Know All of the Division of Workers' Compensation Rules?**

### Objectives:

- List the general principles of the Colorado Division of Workers' Compensation Medical Treatment Guidelines.
- Apply the cervical treatment guidelines to a case.
- Discuss the evaluation procedures recommended in the Colorado Medical Treatment Guidelines for a patient with chronic pain.
- Discuss the role of case management in workers' compensation.
- Explain Rule 17, medical treatment guideline rule; the system of accreditation; and the purpose of the utilization review panel.

## **Do I Really Need to Know All of the Division of Workers' Compensation Rules?**

**Accreditation**      C.R.S. §8-42-101(3.5) and (3.6), and Rule 13

Level I accreditation -      mandatory for chiropractors to treat patients with more than 3 days of lost time, or who may require more than 12 treatments or treatments over a period exceeding 90 days (whichever comes first).

Level II accreditation -      for MDs and DOs only, required for any physician to provide an impairment rating.

Accreditation is for 3 years

**Revocation**      The Director may revoke accreditation for misrepresentation on application; two or more incidents of failure to comply with rules or relevant statutes; or unanimous recommendation by Utilization Review panel.

**Utilization Review Panel, C.R.S. §8-43-501 and Rule 10**

Purpose:      To assure employers pay only for care “reasonably needed at the time of an injury or occupational disease to cure and relieve an employee from the effects of an on-the-job injury”

Committee of 3 providers review care of the provider to determine:

- If change of provider needed – majority vote
- If retroactive denial of payment appropriate – unanimous vote
- If revocation of accreditation recommended – unanimous vote

Musculoskeletal Committee

- 2 practitioners in same discipline of care as provider under review
- 1 occupational medicine practitioner

### **Purpose of the Medical Treatment Guidelines**

- 1) “To foster communication, to resolve disputes between provider, payer, patient” - Rule 17
- 2) “To assure appropriate medical care at a reasonable cost” – C.R.S. §8-40-201(13.5)

## **Provider's Responsibilities Under the Guidelines - Rule 17**

For treatment beyond 6 weeks – prepare a diagnosis-based treatment plan with treatment goals and timeframes for completion. If treatment deviates from the guidelines provide written explanation to payer and patient.

## **Payment for Care - Physician Utilization Reviewers**

The Division of Workers' Compensation expects physician reviewers to consider the ramifications of their decision making and how it affects the case as a whole. For example:

If the procedure being requested is not necessarily recommended, but something more involved like surgery with a prolonged recovery may be the next best option, then it may be logical to approve the requested procedure.

Also, if further physical therapy is requested and the patient is demonstrating functional progression with physical therapy, then typically this would justify an approval of more physical therapy visits beyond what the guidelines recommend.

If the treatment that has been provided clearly meets the indications outlined in the guidelines and the diagnosis has been accepted by the insurer, then treatment should be authorized. Failure to authorize this treatment could result in penalties against the insurer or loss of accreditation by the physician reviewer.

## **Creation of the Treatment Guidelines**

Combination of evidence and consensus.

Peer Group Based – specialist from all disciplines who would treat the medical problem.

## **Current Guidelines**

Low Back, Cervical Spine, Cumulative Trauma Conditions (includes Carpal Tunnel Disorder), Thoracic Outlet, Shoulder, Lower Extremity, Traumatic Brain Injury, Chronic Pain Disorder, Complex Regional Pain Syndrome-1 (RSD).

**General Guideline Principles** (Below is a summary. An example of the complete general principles, taken from the Chronic Pain Disorder Guideline, follows at the end of this section.)

1. **Education** – patient education on self-management of symptoms and prevention. Also includes education of employers, insurers, and family.
2. **Treatment Duration**
  - Begins at initiation of treatment
  - Time to effect - if no effect within limits change treatment or reassess diagnosis
  - Optimum duration - best duration for most cases
  - Maximum duration should not exceed this limit.
3. **Active Interventions**

Passive and palliative treatment only to facilitate active rehabilitation, therapeutic exercise and functional treatment.
4. **Active Therapeutic Exercise**

To improve strength, endurance, coordination, vocational duties.
5. **Positive Patient Response**

Defined by functional gains; e.g., positional tolerance, range of motion, and activities of daily living.
6. **Re-evaluate every 3-4 weeks**

If no positive patient response re-evaluate diagnosis or treatment.
7. **Surgery**
  - For functional gains not purely pain relief
  - Positive correlation of clinical findings, clinical course and diagnostic tests
  - Presence of a pathologic condition
8. **Six-month time frame**

As many as 50% are unlikely to return to work if out for 6 months or more.
9. **Return to Work**
  - This is part of therapy
  - Careful detailed restrictions must be written e.g. – lifting, pushing, pulling, kneeling, driving, tool use, cold environments
  - Be sure you understand patient's job before return to full duty. If unsure obtain advice of occupational professional.
10. **Delayed Recovery**
  - If no progress at 6-12 weeks consider psychosocial evaluation and interdisciplinary treatment.

- 3-10% of patients will fall outside of guidelines for additional treatment. The physician must justify additional treatment showing functional gains.

11. **Guideline Recommendations**

- All recommendations in the Guidelines represent reasonable care in specific cases – regardless of evidence level.
- Other procedures are specified as not recommended

12. **Care Beyond MMI**

- Only chronic pain and CRPS-1 Guidelines contain post MMI care recommendations.
- Other Guidelines are not intended to address post-MMI care.

**Organization of the Guidelines:**

**Initial Diagnostic Procedures**

Hx and PE  
Initial Tests

**Follow Up Diagnostic Imaging and Tests**

**Non-Operative Therapeutic Measures**

Manipulation  
Medication  
Education  
Exercise  
Physical Therapy  
Psychosocial Intervention  
Interdisciplinary Treatment  
Vocational Assessment and Rehabilitation

**Operative Procedures**

**Special Issues**

Diagnosis-Based Treatment and Procedures are found in the Shoulder and Lower Extremity Guidelines  
Cumulative Trauma Guidelines has a unique staging diagram to guide care based on severity.

## **GENERAL GUIDELINE PRINCIPLES – Example from Chronic Pain Disorder Guideline**

The principles summarized in this section are key to the intended implementation of all Division of Workers' Compensation guidelines and critical to the reader's application of the guidelines in this document.

- 1. APPLICATION OF THE GUIDELINES** The Division provides procedures to implement medical treatment guidelines and to foster communication to resolve disputes among the provider, payer and patient through the Worker's Compensation Rules of Procedure. In lieu of more costly litigation, parties may wish to seek administrative dispute resolution services through the Division or the office of administrative courts.
- 2. EDUCATION** of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of chronic pain and disability. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.
- 3. TREATMENT PARAMETER DURATION** Timeframes for specific interventions commence once treatments have been initiated, not on the date of injury. Obviously, duration will be impacted by patient compliance, as well as availability of services. Clinical judgment may substantiate the need to accelerate or decelerate the timeframes discussed in this document.
- 4. ACTIVE INTERVENTIONS** emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.
- 5. ACTIVE THERAPEUTIC EXERCISE PROGRAM** Exercise program goals should incorporate patient strength, endurance, flexibility, coordination, and education. This includes functional application in vocational or community settings.
- 6. POSITIVE PATIENT RESPONSE** Positive results are defined primarily as functional gains that can be objectively measured. Objective functional gains include, but are not limited to, positional tolerances, range of motion (ROM), strength, endurance activities of daily living cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

7. **RE-EVALUATION OF TREATMENT EVERY 3 TO 4 WEEKS** If a given treatment or modality is not producing positive results within 3 to 4 weeks, the treatment should be either modified or discontinued. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.
8. **SURGICAL INTERVENTIONS** Surgery should be contemplated within the context of expected functional outcome and not purely for the purpose of pain relief. The concept of “cure” with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions.
9. **SIX-MONTH TIME FRAME** The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return to work within a six-month timeframe, whenever possible. It is important to note that timeframes may not be pertinent to injuries that do not involve work-time loss or are not occupationally related.
10. **RETURN-TO-WORK** is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations and the patient should never be released to “sedentary” or “light duty.” The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, overhead work, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated.

The practitioner should understand all of the physical demands of the patient’s job position before returning the patient to full duty and should request clarification of the patient’s job duties. Clarification should be obtained from the employer or, if necessary, including, but not limited to, an occupational health nurse, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

11. **DELAYED RECOVERY** Strongly consider a psychological evaluation, if not previously provided, as well as initiating interdisciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6 to 12 weeks after an injury. The Division recognizes that 3 to 10% of all industrially injured patients will not recover within the timelines outlined in this document despite optimal care. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.
12. **GUIDELINE RECOMMENDATIONS AND INCLUSION OF MEDICAL EVIDENCE** Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the level of

evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply:

Consensus means the opinion of experienced professionals based on general medical principles. Consensus recommendations are designated in the guideline as “generally well accepted,” “generally accepted,” “acceptable,” or “well-established.”

“Some” means the recommendation considered at least one adequate scientific study, which reported that a treatment was effective.

“Good” means the recommendation considered the availability of multiple adequate scientific studies or at least one relevant high-quality scientific study, which reported that a treatment was effective.

“Strong” means the recommendation considered the availability of multiple relevant and high quality scientific studies, which arrived at similar conclusions about the effectiveness of a treatment.

All recommendations in the guideline are considered to represent reasonable care in appropriately selected cases, regardless of the level of evidence attached to it. Those procedures considered inappropriate, unreasonable, or unnecessary are designated in the guideline as “not recommended.”

13. **TREATMENT OF PRE-EXISTING CONDITIONS** that preexisted the work injury/disease will need to be managed under two circumstances: (a) A pre-existing condition exacerbated by a work injury/disease should be treated until the patient has returned to their prior level of functioning or MMI; and (b) A pre-existing condition not directly caused by a work injury/disease but which may prevent recovery from that injury should be treated until its negative impact has been controlled. The focus of treatment should remain on the work injury/disease.

# LEVEL I CURRICULUM

## Billing section

### Billing Information (as revised 2015)

#### Objectives:

- State the basis for the Colorado Workers' Compensation medical fee schedule.
- Explain procedures for prior authorization of payment.
- Describe restrictions on physical medicine billing and how time is used for E&M Codes.

# Billing for Workers' Compensation

## Introduction:

Workers' compensation medical providers must familiarize themselves with Rules 16 (Utilization Standards), 17 (Medical Treatment Guidelines [MTG]) and 18 (Medical Fee Schedule [MFS]). As we will discuss, the workers' compensation fee schedule consists of: the actual Rule 18, *Relative Values for Physicians*® (RVP®) (copyright by 2013 OptumInsight, Inc.), and is supplemented with the Director's Interpretive Bulletin 13 for the applicable year.

Rules 16 and 18 work hand-in-hand, with Rule 16 establishing the processes and procedures for billing as between the payers and medical providers, and Rule 18 directly addressing the actual fees.

As required by statute, the Division's Medical Policy Section conducts an evaluation of the fee schedule and the applicable conversion factors listed in Rule 18. The fee schedules are reviewed on or before July 1 of each year and take effect on January 1 of the following year. When the fee schedule is revised, also incorporated is the prior year edition of the RVP® for payments of medical services, the American Medical Association's (AMA) Current Procedural Terminology (CPT®) for codes, descriptions, parenthetical notes and coding guidelines unless modified by rule, and the Medicare Severity Diagnosis Related Groups (MS-DRGs) Definitions Manual for inpatient hospital stays. In addition, the Director's Interpretive Bulletin No. 13-15 (IB 13-15), available on the Division's website ([www.colorado.gov/cdle/dwc](http://www.colorado.gov/cdle/dwc) -- click on "Official Forms, Publications, and Interpretive Bulletins")-- provides clarification of codes, a listing of the Division created codes with descriptors and suggested relative value units (RVUs) for some codes missing RVUs in the RVP®.

## Explanation and Use of Conversion Factors

A conversion factor (CF) is used to turn the RVUs listed in the fee schedule into a dollar amount for the service rendered. Annual reimbursement amounts may be impacted by changes to the American Medical Association's (AMA) copyrighted Current Procedural Terminology (CPT®) system, the assigned RVUs, restrictions in the RVP®'s guidelines and the Division established conversion factors. Changes to CPT® coding and the RVUs are outside the domain of the Division. Current conversion factors are listed later in this chapter under the section discussing Rule 18.

# Rule 16 – Utilization Standards

Rule 16 defines workers' compensation standard terminology, administrative procedures, and dispute resolution procedures. It requires all providers and payers to use Rules 16, 17 (MTG) and 18 (MFS).

- To be eligible for reimbursement under Workers' Compensation Act, a medical provider must be an authorized treating provider as defined in Rule 16-2(B).
- 16-3 prohibits payers from dictating the type or duration of medical treatment or from imposing their own internal guidelines or other standards for medical determination, and requires that payers and providers utilize the Medical Treatment Guidelines to support treatment plans.
- 16-4 establishes that providers report services in accordance with codes and standards in Rule 18-Medical Fee Schedule that accurately represents the services provided. The MFS limits the maximum fees to be paid, but it does not limit the billed charge. The Division Director or an Administrative Law Judge (ALJ) may subject a provider to penalties under the Workers' Compensation Act for inaccurate billing when the provider knew or should have known that the services billed were inaccurate.
- 16-5 lists the types of Division-recognized health care providers. Any medical provider not listed in 16-5 must have prior authorization from the payer before providing services. All non-physician providers must have a referral from an authorized treating physician; the payer or employer may not redirect or alter the scope of an authorized treating provider's referral. The authorized treating physician making a referral is required to clarify any questions concerning the scope of the referral, prescription, or the reasonableness or necessity of the care.

## Out-of-State Providers

In the event the injured worker moves out-of-state or is referred to an out-of-state provider, the necessary procedures are outlined in Rule 16-5(B). The referring physician must accept the responsibility for complying with the 5 requirements listed therein.

## Handling, Processing and Payment of Medical Bills

The use of agents such as preferred provider networks, bill review companies, third party administrators, and case management companies does not relieve the employer or insurer from their legal responsibilities for compliance with these rules.

Reimbursement for medical services shall not exceed the amount allowed by the adopted edition of the RVP<sup>®</sup> for that date of service or the billed amount, whichever is less. Some codes in the RVP<sup>®</sup> have yet to be assigned RVUs, and in some cases the Division may

have suggested values in Rule or in the Director's Interpretive Bulletin 13. If no value exists or you are billing for a service not identified in the fee schedule, you must obtain prior authorization from the payer. Since the payer will establish a value for these services by considering the complexity, time, level of training, and expertise required to perform the service, you have the right to request their methodology. Payers contesting a provider's treatment must follow the procedures set forth under Rule 16.

## **Rule 16-7 and 16-8: Required Billing Forms and Accompanying Documentation**

All billed services shall be itemized on the appropriate electronic or paper billing form (professional services use CMS 1500<sup>1</sup>), with the appropriate billing codes and modifiers from the fee schedule. National provider identification (NPI) numbers are required for workers' compensation bills; providers who cannot obtain NPI numbers are exempt from this requirement. Any services not billed on the proper forms or using the appropriate billing codes may be contested until the provider complies (Rule 16-7(D)).

WC164 form: In addition to the appropriate billing form, the provider needs to submit accompanying documentation, which shall include copies of the relevant examination, surgical, and/or treatment records. The authorized treating physician designated to see the patient at the outset must complete items 1-7 and 10 on the initial Division WC164 form after the patient's first visit. Certain information, such as the insurer's claim number, may not be known and can be omitted. The initial WC164 shall be submitted to the payer, with a copy to the injured worker, no later than fourteen (14) days from the date of service. All supporting documentation shall be submitted to the payer at the time of billing unless other agreements have been established. Reimbursement for the completion of the WC164 form is covered in Rule 18-6(G)(4) (currently \$47.00).

When the patient reaches maximum medical improvement (MMI) for all injuries or diseases covered under this workers' compensation claim, the primary provider submits a WC164, specifying "closing" and completing items 1-5, 6 B and C, 7, 8 and 10. If the worker has sustained a permanent impairment, then item 9 must be completed as well and a Level II accredited physician must attach all necessary permanent impairment rating reports. Non-Level II accredited physicians should complete the MMI data and notify the insurer they are not Level II accredited or provide the name of the Level II accredited physician designated to perform the permanent impairment rating.

The payer may contest reimbursement for billed services until the provider completes and submits the required accompanying documentation.

Rule 16-8 sets forth the minimal requirements for medical record documentation to substantiate the services billed. The documentation should detail at least the following information per contact or, at a minimum for cases where contact occurs more than once a week, be summarized once per week:

---

<sup>1</sup> CMS1500 (version 02-12) was effective April 1, 2014. This latest version incorporates electronic standards for billing and can accommodate billing under ICD-9 or 10.

- (1) Patient's name;
- (2) Date of contact, office visit or treatment;
- (3) Name and professional designation of person providing the billed service;
- (4) Assessment or diagnosis of current condition with objective findings;
- (5) Treatment status or patient's functional response to current treatment;
- (6) Treatment plan including specific therapy with time limits and measurable goals and detail of any referrals;
- (7) All pertinent changes to work and/or activity restrictions and
- (8) All prior authorization(s) for payment received from the payer (i.e., who approved the prior authorization for payment, services authorized, dollar amount, length of time, etc.).

### **Rule 16-9 and 16-10: Obtaining and Contesting Prior Authorization**

In general, prior authorization for payment is requested when:

- (1) A prescribed service exceeds the recommended limitations set forth in Rule 17, the Medical Treatment Guidelines;
- (2) The MTGs otherwise require prior authorization for that specific service;
- (3) A prescribed service is identified in Rule 18 as requiring prior authorization or where the service will exceed a given limitation;
- (4) A prescribed service is not identified in the fee schedule (see Rule 16-9).

Authorization for a prescribed procedure may be granted immediately and without medical review. The payer must respond to all requests for prior authorization within seven (7) business days from the receipt of the provider's request. The Division recommends payers confirm in writing to providers and all parties when a request for prior authorization is approved.

To complete a request, the provider shall explain the medical necessity of the service and provide relevant supporting medical documentation, the latter defined as the documents used in the provider's decision-making process to substantiate the need for the requested service. Include whether the treatment has shown improvement to function for this patient, such as return-to-work or in activities of daily living.

To avoid disputes, the Division recommends using the Prior Authorization Request form (WC188).

If the payer wishes to contest prior authorization they must comply with Rule 16-10, including a medical review where the contest is for medical reasons or solely for work-relatedness. The payer must notify the provider and parties, in writing, of the basis for the contest within seven (7) business days whether denying for medical or non-medical

reasons (such as no claim has been filed, etc.), and included the name and credentials of the medical reviewer. A certificate of mailing of the written contest must also be sent.

Once a denial has been received, the requesting medical provider has 7 business days from the date of the certificate of mailing to provide a written response. The payer then has 7 days to respond. In the event of an unresolved dispute, the parties should seek resolution and adjudication available through the Division and/or the Office of Administrative Courts. An urgent need for prior authorization as recommended in writing by the authorized treating provider is good cause for an expedited hearing. Unreasonable delay or denial as determined by the Director or an Administrative Law Judge (ALJ) may subject the payer to penalties. Rule 16-9(I):

“If, after the service was provided, the payer agrees the service provided was reasonable and necessary, lack of prior authorization for payment does not warrant denial of payment.”

If you have complied with the rules for prior authorization but the payer does not respond in a timely manner, Rule 16-10(E) provides that payment is automatically authorized unless a hearing is timely requested and the parties involved are appropriately notified.

### **Rule 16-11: Payment of Medical Benefits**

Medical providers must submit their bills within 120 days of the date of service pursuant to Rule 16-7(F). The date of receipt can be determined by the payer’s date stamp or electronic acknowledgement date. Otherwise, receipt is presumed to be 3 days after date the bill was mailed. Because of these timelines, providers should double-check the address to assure they are mailing to the correct office. The payer has 30 days [Rule 16-11(A)(2)] from the date of receipt to either pay the bill or to justify denial.

If the injured worker has paid the provider for authorized care, the payer must reimburse the worker for the full amount s/he paid. Note that the payer may also collect from the provider any over-payment difference between that amount and the allowable reimbursement under the fee schedule. [Rule 16-11(G)]

If the payer is not in compliance with the timely payment rules, the provider should first attempt to resolve the issue with the payer. If the problem persists, the provider may seek the assistance of the Division’s Carrier Practices Unit or the Division’s Medical Policy Section/Dispute Resolution process. [Rule 16-11(E)]

Like prior authorization, contest of payment for a medical service may be for medical [Rule 16-11(A)] or non-medical [Rule 16-11(B)] reasons. In all cases where the payer is contesting the payment of billed services, the payer shall notify the billing party within 30 days of receipt of the bill. This notification should provide the provider with:

- Name of the injured worker,
- Specific identifying information coordinating the notice with any payment instrument associated with the bill,

- Date(s) of service in question, Payer's claim number and/or Division's workers' compensation claim number
- Reference to the specific bill and each item being contested,
- Notice that the billing party may resubmit the bill or corrected bill within sixty (60) days,
- Notice that the injured worker shall not be balance-billed for services related to the work-related injury or occupational illness,
- Name of the insurer with admitted, ordered or contested liability for the WC claim,
- Name, address, e-mail (if any), phone number and fax of a person who has responsibility and authority to discuss and resolve disputes on the bill,
- If applicable, acknowledgement of specific uncontested and paid items submitted on the same bill as the contested services,
- If applicable, a statement that the payment is being held in abeyance because a relevant issues is being brought to hearing,
- An explanation of the clear and persuasive medical reasons for the decision, including the name and professional credentials of the person performing the medical review and a copy of the medical reviewer's opinion,
- Citing of appropriate statutes, rules and/or documents supporting the payer's reasons for contesting payment, and
- Identification of information most likely to influence the reconsideration of the contest when applicable,
- A certificate of mailing.

When contesting payment for medical reasons or solely for work-relatedness, the payer shall have the contested item(s) reviewed, within 30 days of receipt of the bill, by a physician or other healthcare professional holding a license and in the same or similar specialty as would typically manage the item under review. The reviewer may call the provider to expedite the process; however, the written contest of payment is still due within the 30 day period. The medical provider has 60 days to appeal the contest of payment. See Rule 16-11(D) for required documentation to include in the appeal.

Upon receipt of the resubmission, the payer has 30 days to process the appeal. If the contest of payment continues, the provider may approach the Division's Medical Policy Section for assistance (Rule 16-11(E)). The provider should submit to the Division a copy of the original or corrected bill with the contested codes and dates of services in dispute, a copy of the payer's explanation as to why the billed services are being contested, a statement of the specific item(s) contested, clear and persuasive supporting

documentation or reasons for the appeal, and any available additional information requested in the payer's written notice.

### **Rule 16-11(F) Retroactive Adjustments of Medical Bills**

Rule 16-11(F) limits the retroactive adjustment of payments. All medical bills are considered final unless a hearing is requested within the 12-month period and the requesting provider is notified that the payment is being contested and the matter is going to hearing. If the payer conducts a retroactive review to recover overpayments from a provider based on *medical* reasons, the payer shall have the bill and all supporting documentation reviewed by a physician or other health care professional as defined in Rule 16-5(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures or treatment under review.

Regardless of whether the retroactive review to recover overpayments is based on medical or non-medical reasons, the payer's written notice must provide detailed information as set forth in Rule 16-11(F)(3).

If there is a continued disagreement, the parties should follow the Dispute Resolution process or adjudication procedure available through the Division or the Office of Administrative Courts. Further, as noted earlier, an injured worker shall never be required to directly pay for admitted or ordered medical benefits covered under the Workers' Compensation Act, and shall be reimbursed if that has occurred.

# Rule 18 – Medical Fee Schedule

## Billing with the Fee Schedule

Seeking reimbursement for medical services requires the submission of the CMS 1500, adherence to the guidelines within the Relative Values for Physicians ( RVP<sup>®</sup>), the Division’s adopted fee schedule (Rule 18) as well as Rules 16 and 17.

## Parts of Rule 18 Modify or Follow the General Layout of the RVP ©

Rule 18-5 lists certain instructions and modifications made by the Division to the RVP<sup>®</sup>. Interim values, indicated by an “I” in the left-hand margin for the RVP<sup>®</sup>, are accepted as a basis of payment; however deleted codes, marked by an “M”, are not. Codes listed with RVUs of “BR” (by report) and “RNE” (relativity not established) require prior authorization per Rule 16. Payment should be in compliance with Rule 16-6(B).

## Fee Schedule Calculations

To properly bill for services, providers must use the codes currently in effect for workers’ compensation cases. The use of improper codes will cause payers to return the bills for re-coding and delay payment. These codes and their RVUs are found in the RVP<sup>®</sup>, Rule 18 (Division-created codes), and the Director’s Interpretive Bulletin (IB 13) for the respective year. (See a quick-reference list of some Division-created codes at the end of this chapter.)

When billing for services rendered, the CPT<sup>®</sup> code must be related to one of the diagnostic codes (ICD-9) listed in *Item 21: Diagnosis or Nature of Illness or Injury* section of the CMS 1500. The workers’ compensation fee schedule is a “maximum fee schedule,” meaning the carrier will reimburse the provider either the amount billed or the fee schedule amount, whichever is less. Providers should bill their usual and customary amount. To verify payments received, the provider must multiply the relative value units times the conversion factor for the respective code as established in Rule 18, taking into consideration any applicable modifiers (to be discussed later) or contractual agreements. The codes from the RVP<sup>®</sup> and the respective Conversion Factors [Rule 18-4] divide into the following sections for purposes of calculating reimbursement:

<u>RVP section</u>	<u>Conversion facton (CF)</u> <u>Eff. 1/1/15 – per RVU</u>
Anesthesia	\$53.73
Surgery	\$99.83
Radiology	\$18.41
Pathology	\$13.72
Medicine	\$ 8.33
Physical Medicine (includes nutrition therapy & acupuncture)	\$ 6.23
E&M	\$10.16

As an example, the reimbursement for a new patient E&M service on January 3, 2015 would be calculated by:

**6.5** (99201 Code RVUs from the 2014 edition\*\* of the RVP©) x **\$10.16** (E&M Conversion Factor from Rule 18-4 effective 01/01/15.) = **\$66.04** (maximum allowed reimbursement)  
(\*\*Remember the 2014 edition is used in 2015)

## Time Based Procedures

Certain codes are time-based and require an additional step. For instance, a code listed as 8.0 units per 15 minutes must include under the Unit/Day column of the CMS 1500 the number of 15 minute periods used. Treatment for 45 minutes with a 15-minute based unit value would show the number 3 in the “Unit/Day” column of the CMS 1500 and be calculated by:

$[8.0 \text{ (RVUs per 15 minutes)} \times 3 \text{ (number of 15 minute periods)}] \times \text{CF (respective area)} = \text{maximum reimbursement.}$

## Modifiers

Numeric modifiers may impact the reimbursement level. The RVP© and CPT® contain a complete list of the modifiers. A modifier –26 indicates the provider is billing only for the professional component and requires the use of the RVUs listed for that modifier in the RVP©. The respective sections of the RVP© provide explanations of the professional and technical (modifier –TC) components of codes. Other common modifiers are:

- 25 Indicates that on the day a procedure or service identified by a CPT® code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. This modifier is required to be appended to the E&M service if an E&M service is billed with manipulation. The value of manipulation includes pre- and post-manipulation assessment that must stand separate from a separately performed, reported, and billed E&M service. The E&M service report must be reported separately from the manipulation service.
- 51 Indicates multiple procedures at the same session by the same provider. For surgical-related services, see the RVP’s © surgery guidelines for more detailed instructions.

## **Other Factors Impacting Reimbursement, including Medical Treatment Guideline Directives and “Global Period” application**

The provider’s billing office should become familiar with the limitations and restrictions contained in Rule 17 (the Medical Treatment Guidelines) and Rule 18. These rule-generated limitations may involve time limits, level of training necessary to provide the service, limits to number of treatments (in tandem with the treatment guidelines), etc.

In addition, podiatrists’ offices should be familiar with the “Surgery Guidelines” as given in the surgical section of the RVP<sup>®</sup>, giving particular attention to the use of modifiers to identify bilateral procedures, multiple surgical procedures on the same day in the same operative setting, use of two surgeons, a surgical team, and assistants at surgery. “Global period” is a term most commonly seen in surgery and refers to the pre-and post-operative time period. It is listed in the Surgery Section Guidelines of RVP<sup>®</sup> and CPT<sup>®</sup>), and Rule 18-5(D)(2)(f), and certain E&M code modifiers may also be applied.

### **Rule 18-5(E)-Radiology, and 18-5(F)- Pathology**

These sections are relatively straightforward. Always indicate how much of a radiology or pathology procedure or lab was completed by billing the appropriate modifier. The appropriate modifiers are -26 (professional), -TC (technical component).

The RVP<sup>®</sup> defines the professional modifier (-26), and technical modifier (-TC) of a radiology, pathology or laboratory procedure or test. Modifier -26 indicates that the medical professional’s interpretation and written report of the procedure or test, and/or the examination of the patient, was completed. The technical component modifier (-TC) applies only to the equipment, materials, space, technical personnel, and other overhead necessary to conduct and complete the test or procedure.

Note: When reviewing a report from a radiologist or pathologist, it is not appropriate to bill the radiology code with the -26 modifier. If a physician interprets the same radiological image more than once, or if multiple physicians interpret the same radiological image, only one interpretation is reimbursed. The time a physician spends reviewing and/or interpreting an existing radiological image is considered a part of the physician’s evaluation and management service code.

**Pathology:** Rule 18-5(F) explains billing for interpretive reports beyond any computer generated values, as well as consultations between the pathologist and the ordering physician.

## **Rule 18-5(G): Medicine –Biofeedback – Manipulation – Psychology**

### **Biofeedback**

Biofeedback [Rule 18-5(G)(3)] is limited to the number of visits recommended in the Medical Treatment Guidelines. You must have prior authorization to exceed the guidelines. Unless provided or supervised by a physician or psychologist with evidence of biofeedback training, the person providing the biofeedback shall be certified by the Biofeedback Certification International Alliance (BCIA).

### **Chiropractic/Osteopathic Manipulation**

Manipulative therapy is limited to the maximum allowed in the relevant Rule 17 medical treatment guideline. Prior authorization from the payer is necessary before billing for more than four body regions in one visit. The provider's medical records must reflect medical necessity and prior authorization for payment when treatment exceeds these limitations.

An E&M office visit may be billed on the same day as the manipulation code when the documentation meets the E&M requirement and an appropriate -25 modifier is used.

### **Psychology**

Physicians and licensed psychologists (PsyD, PhD, EdD) are reimbursed for the amount billed up to the maximum fee schedule allowed amount. Other non-physician providers performing psychological / psychiatric services are reimbursed at 75% of the fee schedule allowed amount.

Providers should review Rule 18-5(G)(6)(b) for time limitations on evaluations, testing and psychotherapy sessions, keeping in mind that with documented prior authorization these limits may be extended. Special attention should be paid to diagnostic interview codes, as some are reimbursed on a per minute basis.

## **Rule 18-5(H) - Physical Medicine Billing**

The following restrictions are found in Rule 18-5(H). The numbered references are to the rule's subsections:

- (1) *Medical nutrition therapy* requires prior authorization.
  
- (3) Special Note to All Physical Medicine and Rehabilitation Providers

Prior authorization shall be obtained from the payer for any physical medicine treatment exceeding the Medical Treatment Guideline recommendations as set forth in Rule 17.

The injured worker shall be re-evaluated by the prescribing physician within 30 calendar days from the initiation of the prescribed treatment and at least once every month while that treatment continues. Prior authorization for payment shall be required for treatment of a condition not covered under the Treatment Guideline(s) and exceeding 60 days from the initiation of treatment.

- (4) *Interdisciplinary Rehabilitation Programs* – (Requires prior authorization): An interdisciplinary rehab program is one that provides focused, coordinated, and goal-oriented services using a team of professionals from varying disciplines to deliver care. These programs can benefit persons who have limitations that interfere with their physical, psychological, social, and/or vocational functioning. As defined in Rule 17, rehabilitation programs may include, but are not limited to: Chronic Pain, Spinal Cord, or Brain Injury programs.

**Billing Restrictions:** The billing provider shall detail to the payer the services, frequency of services, duration of the program and their proposed fees for the entire program, inclusive for all professionals. The billing provider and payer shall attempt to mutually agree upon billing code(s) and fee(s) for each Interdisciplinary Rehabilitation Program.

- (5) *Therapeutic Procedures:* Unless the provider's medical records reflect medical necessity and the provider obtains prior authorization for payment from the payer to exceed the one-hour limitation, the maximum amount of time allowed is one hour of procedures per day, per discipline. Examples of such procedures are: therapeutic exercise, massage, acupuncture, and manual therapy techniques.
- (6) *Modalities:* Modalities, whether attended or unattended, time or not timed, are limited to two per visit per discipline.

Keep in mind that several physical medicine procedures or modalities require prior authorization from the payer BEFORE they are performed. Examples include: work conditioning, pain management, etc. See section 18-5(H)(6) for special instructions on billing for use of a TENS unit, and for dry needling of trigger points.

PTs, OTs and Athletic Trainers are referred to Rule 18-5(H)(7) for clarification of office visit billing.

## **Evaluation and Management – Rule 18-5(I)**

### **Rule 18-5(I)(1) - Disability Counseling Definitions**

For the most part, time is not a factor when determining the level of E&M code to be billed. The criteria as outlined in the guidelines at the beginning of the E&M section are to be applied. However, if 50% of the physician's time is spent counseling the patient on disability and/or coordination of care related to the workers' compensation injury, time may

become the overriding factor to the determination of the appropriate level of office visit. Detailed, specific supporting documentation is also required and must pertain directly to the current visit.

Examples of billable, follow-up visits would be cases in which the patient is re-evaluated because of insufficient progress (thus requiring a change in the treatment regimen), presentation of a new complaint, or complications. These must be documented in the provider's notes.

Furthermore, since the Division stresses that the provider actively educates and counsel the patient, occasions when such services are provided would be billable. In these instances the specifics of the counseling and/or education and the time spent face-to-face with the patient must be clearly documented in the record to determine the proper level of office visit.

E&M documentation guidelines are discussed at the end of this curriculum chapter.

### ***Some Division-Established Codes & Values***

*(at the end of this curriculum section is an Appendix of Division-created codes)*

Particular attention should be paid to Division-created codes; typically they start with the letter "Z" followed by 4 digits, and often are referred to as "Z-codes". A complete list of the Division-created codes can be found in the Director's Interpretive Bulletin 13 for the applicable calendar year.

**Rule 18-5(I)(2) New Patients defined:** defines a new injury as a New Patient even if the provider has seen the patient within the last three years. Any subsequent visit would then be an established patient code.

Without prior authorization, there is a limit of one office visit by each professional per patient, per day, per workers' compensation claim.

#### **Rule 18-5(I)(5) - Face-to-face or Telephonic Treating Physician or Qualified Non-physician Medical Team Conferences**

A medical team conference can only be billed if all of the criteria listed in the CPT® are met. If there is a single biller for the entire rehabilitation program and a daily per diem rate has been mutually agreed upon, use the Division billing code Z0500.

**Rule 18-5(I)(6) - Face-to-face or Telephonic Meeting by a Non-treating Physician with the Employer, Claim Representatives or any Attorney** In order to provide a medical opinion on a specific workers' compensation case but the medical provider does not create a specific report, or no written record is created after this meeting: Bill Division Code Z0601 at \$65.00 per 15 minutes to the party requesting the meeting.

**Rule 18-5(I)(7) - Face-to-face or Telephonic Meeting by a Non-treating Physician with the Employer, Claim Representatives or any Attorney** in order to provide a medical opinion on a specific workers' compensation case and the provider creates a report or written record after the meeting; Bill as a 'special report' [Rule 18-6(G)(4)].

### **Rule 18-6(B) - Patient Cancellations**

Rule 18-6(B) allows for the billing of appointments when the patient has not shown up. This allowance is permitted **only** when the **payer** has made the appointment. Reimbursement is one-half of the usual fee for the scheduled visit or \$150.00, whichever is less, and billed with Division Code Z0720. Since the payer needs to be apprised of the patient's active involvement in his/her recuperation, the provider should notify the payer within two (2) business days when a patient does not keep an appointment, and agree to reschedule only if the payer sets the next appointment.

### **Rule 18-6(C) - Copying Fees**

Copying fee rates (and copying of microfilm) are found in Rule 18-6(C). In addition to the rates, the provider of the copies may charge actual postage and shipping costs, and any applicable sales tax.

### **Rule 18-6(D) - Deposition and Testimony Fees**

To agree-upon testimony or deposition fees and costs, all parties should consult and seek to abide by The Interprofessional Code, currently or alternatively titled *Colorado Interprofessional Guidelines*, prepared by the Colorado Bar Association, the Colorado Medical Society and the Denver Medical Society. A copy of these guidelines is included in this manual. In the absence of an agreement, the guidance and coding set forth in Rule 18-6(D) should be followed. Pertinent timelines are also established in this rule.

## Payment for Report Preparation - Division codes

### Routine Reports

Routine reports, such as diagnostic tests, procedure reports, progress notes, office notes, operative-reports, are considered to be part of the normal communication between provider and payer and are not specifically reimbursable. An exception to this is the form WC164:

### “Physician’s Report of Workers’ Compensation Injury” (form WC164)

After the initial contact with the patient, the primary authorized physician should complete a WC164, marking it to indicate an initial report. This report is reimbursable under Z0750 in the amount of \$47.00. When a patient reaches MMI and there is no permanent impairment, the physician is required to complete the WC164, closing, for which they may bill Z0752 with a maximum reimbursement of \$47.00 pursuant to Rule 18-6(G)(2)(b) and (e). A Division-created code Z0753 is established to represent those cases where the initial report *and* closing are reported on the same date of service.

The provider should review again the information in Rule 16-7(E)(1) regarding the required fields and timelines for the WC164.

When *the payer asks* a medical provider to complete additional WC164s to use for interim appointments, and the form requires 15 minutes or less to complete, the provider should bill using code Z0754, for \$47.00 per completed form.

### Special Reports

Special reports are any reports not otherwise addressed under Rule 16, 17 or 18, including any form, questionnaire or letter with variable content. This includes any independent medical evaluations or review (non-Division IMEs) and treating or non-treating medical reviewers or evaluators producing written reports pertaining to injured workers. Special reports also include payment for meeting, reviewing another’s written record and amending or signing that record.

Reimbursement for preparation of special reports or records requires prior agreement with the requesting party. Because narrative reports may have variable content, the content and total payment shall be agreed upon by the provider and the report’s requester before the provider begins the report. If requested, the provider is entitled to a two-hour deposit in advance in order to schedule any associated patient exam.

The timeline for cancellations of special report requests is found in Rule 18-6(G)(4). The maximum allowable fee for a special report is \$325.00 per hour billed in 15-minute increments. For a *written* report or for a patient discharge letter required by statute §8-43-404(10)(a), use Division code Z0755. For an IME or a report involving a patient exam use Z0756. For the completion of a lengthy form use Z0757.

## **Supplies, Supplements, Herbs**

Supplies not integral to perform a service or procedure are reimbursed in accordance with Rule 18-6(H). The use of supplements and herbs generally requires prior authorization and agreement of the amount to be reimbursed, unless the recommendations are specifically provided-for in Rule 17, Medical Treatment Guidelines. The provider should follow the requirements listed under Rule 16-9 to obtain the authorization necessary. References to billing for herbs and supplements are found in Rule 18-6(M)(6) and 18-6(O)(3)(c).

## **Acupuncture – Rule 18-6(O)**

Licensed Acupuncturist (LAc), or acupuncturists certified by an existing licensing board are limited to treatment frequencies established in the applicable Medical Treatment Guideline. Prior authorization must be sought to be paid for treatments in excess of those frequencies.

## **Use of an Interpreter – Rule 18-6(P)**

Rates and terms shall be negotiated with prior authorization except for emergency treatment. The billing code is Z0722.

---

## Supplement – E&M Documentation Guidelines as set forth in Exhibit #7 to Rule 18

***The following information is NOT specifically covered in the exam you will be taking for this course; however, these guidelines are important to review and understand as the scope of your documentation will often be linked to the fee/billing amount(s) and levels that you are requesting. See the actual Exhibit #7 for more detailed information.***

### Evaluation and Management (E&M) Documentation Guidelines

Exhibit #7 clarifies the necessary documentation needed to obtain a particular level of E&M office visit level. Providers can use either the “1997 E&M Documentation Guideline” as developed by Medicare and available on Medicare’s website, or the Division’s edited version of Medicare’s 1997 E&M Documentation Guidelines as set forth in Exhibit #7 to Rule 18. The provider must determine which E&M Documentation Guideline will be used and that guideline criteria must be met to determine the level of office visit. The provider cannot interchange components from both guidelines.

In both E&M Guidelines and AMA’s CPT®) E&M code criteria the level of a provider’s visit is determined by either:

- A. Documentation of these **three relevant and legible Key Components**:
1. History,
  2. Exam, and
  3. Medical Decision Making (MDM)
    - (Requires all three key components for initial visits or two of the three key components to be at the same level or higher to qualify for a billable level)

**OR**

- B. **Time** if > 50% of the visit is face to face patient counseling or coordinating care. Time and the specifics of counseling and or coordination of care must be documented in the record.

The overall billable level *requires the provider to determine the level* for each of the above-listed **key components** (history, exam, and MDM).

### **1. HISTORY COMPONENT**

The History Key Component has three subsets of information in both Medicare 1997 E&M Documentation Guidelines and in Exhibit # 7

- History of Present Illness (HPI)
- Review of Systems (ROS)

- Past Medical, Family, and Social histories (PMFSH) -- except Exhibit #7 establishes *four* PMFSH instead of 3 as used in Medicare’s 1997 E&M Documentation guidelines:
  1. Past Medical,
  2. Family,
  3. Occupational/Social +
  4. Non-occupational/Social histories

***History of the Present Illness/Injury(s) (HPI):***

Documentation of a **Chief Complaint** is always necessary for any injured worker visit. The chief complaint is normally stated from the injured worker:

- How the accident occurred
- What hurts and or what injury(s) was sustained;

The documentation should answer the question of “why” the patient is in to see you today. Medical necessity of the visit essentially is determined by answering this question.

The *History of the Present Illness/Injury(s) (HPI)* level is determined by well-documented the answers to probing questions posed to the injured worker about the chief complaint. The number of the following items documented determines the level (example using the C-Spine):

1. Location – neck
2. Quality – the pain is dull
3. Severity – the dull pain is a 5 out of 10
4. Duration – the dull pain is there all the time
5. Timing - the dull pain is worse at night
6. Context - the pain is sharp when I bend my head down
7. Modifying Factors – sitting still helps, but bending over makes it worse
8. Associated Signs – sometimes at night I feel a numbness in my left arm.

To obtain an “**Extended**” *History of the Present Illness/Injury(s) (HPI) Level*:

- **Initial visit** requires:

- Discussion of **the causality** of the worker's injury(s) as they relate to his/her job duties.
- **Established visit** requires:
  - A detailed description of the **patient's progress with the current treatment plan**, which should include a discussion of **objective functional gains/losses, ADL's etc.**

### ***Review of Systems (ROS)***

ROS remains consistent with CPT and Medicare's 1997 E&M Documentation Guidelines and Exhibit #7. The provider is seeking additional information that may help narrow the number of plausible diagnoses:

- Constitutional symptoms (e.g., fever, weight loss)
- Eyes, ears, nose, mouth, and throat
- Cardiovascular / respiratory
- Musculoskeletal
- Psychiatric
- Gastrointestinal . . . and all other major physiologic/neurologic systems

Documentation of all pertinent ROS systems with either a positive or negative response is necessary to be counted. Determine and document if anything has changed since the last visit in established patients.

### ***Past Medical, Family, and Social Histories***

The PMFSH reviews four areas (NOTE: *Employers* should *not* have access to any patient's or the family's generic/hereditary diagnoses or testing information, etc.)

1. Past history – the patient's past experiences with illnesses, operations, injuries and treatments;
2. Family history – a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk and any family situations that can interfere with or support the injured worker's treatment plan and returning to work;
3. Occupational/Social History – an age appropriate review of past and current work activities, occupational history, current work status, any work situations that support or

interfere with return to work. For established visits specific updates of progress must be discussed.

4. Non-Occupational/Social History – Hobbies, current recreational physical activities and the patient’s support relationships, etc. Social histories also include other inquiries such as hobbies, recreation, drug/alcohol/tobacco use, level of education, marital status, financial status, and the patient’s available support systems. For established visits specific updates of progress must be discussed.

**LEVEL OF HISTORY TABLE FROM EXHIBIT #7**

	<b>Requirements for a Problem Focused (PF) History Level</b>	<b>Requirements for an Expanded Problem Focused (EPF) History Level</b>	<b>Requirements for a Detailed (D) History Level</b>	<b>Requirements for a Comprehensive (C) History Level</b>
History of Present Illness/Injury (HPI)	Brief 1-3 elements	Brief 1-3 elements	Extended 4+ elements (required a detailed patient specific description of the patient’s progress with the current TX plan, which should include objective functional gains/losses, ADLs)	Extended 4+ elements (requires a detailed patient specific description of the patient’s progress with the current TX plan, which should include objective functional gains/losses, ADLs)
Review of Systems (ROS) is not required for established patient visits.	None	Problem pertinent – limited to injured body part	2 to 9 body parts or body systems	Complete 10+
Past Medical, Family and Social/Work History (PMFSH)	None	None	Pertinent 1 of 4 types of histories	2 or more of the 4 types of histories

**2. PHYSICAL EXAM COMPONENT**

This component is specific and the total number of body parts/system documented and points or “bullets” obtained determines the level of the physical examination. The number of bullets applied is tied to the extent to which the exam is detailed and well-documented, which in turn determines the level that can be billed. Those levels are categorized as:

- Problem-Focused
  
- Expanded Problem Focused

- Detailed
- Comprehensive

### ***Example of a Lumbar Back Pain Physical Exam***

- Male Vital signs (*1 bullet* for listing three) :
  - B/P 116/65, Pulse 76 and regular, Respiration – 14 and non-labored,
  - Weight – 330 pounds
  - Height – 6’0”
- Well groomed, obese male without any obvious deformities. (*1 bullet* for comment on appearance)
- No gait dysfunction noted (*1 bullet* for comment on “gait and station”)
- Musculoskeletal Examination – (*1 bullet* for three musculoskeletal assessments of the lumbar spine)
  - Lumbar spine alignment feels normal with no obvious deformities or masses palpated.
  - Pain with bending forward at Flexion 40 degrees, extension 5 degrees and lateral flexion 10 degrees bilaterally
  - Lumbar spine paraspinal muscles tender,
- Neurological Examination – (*4 bullets*)
  - Bilateral Deep tendon reflexes 2+ for achilles and patellar
  - Decreased sensation at the L3/L4 dermatome in his left leg and normal in his right leg
- Psychiatric examination – (*1 bullet*)
  - No agitation or anxiety was noted at this visit
  - Patient states he is being woken up due to pain in his low back and left leg down to his knee
  - Patient states the pain keeps him from participating in his usual fall sport (league football).

**TOTAL of 9 bullets** for this examination = a “detailed” exam. See the table below for further explanation.

**Level of Examination Table from Exhibit #7:**

<b>Level of Examination Performed and Documented</b>	<b># of Bullets Required for each Level</b>
Problem Focused	1 to 5 elements identified by a bullet as indicated in this guideline
Expanded Problem Focused	6 elements identified by a bullet as indicated in this guideline
Detailed	7-12 elements identified by a bullet as indicated in this guideline
Comprehensive	> 13 elements identified by a bullet as indicated in this guideline

**3. MEDICAL DECISION MAKING (MDM) COMPONENT** – three tables (areas) will determine the Level of MDM

1. # of Diagnosis & Management Options
2. Amount and/or Complexity of Data Reviewed
3. Table of Risk

**From Exhibit #7:**

<b>Level of Risk</b>	<b>1. # of Points for the # of Dxs and Management Options)</b>	<b>2. # of Points for Amount and Complexity of Data)</b>	<b>3. Level of Risk</b>
Straightforward	0-1	0-1	Minimal
Low	2	2	Low
Moderate	3	3	Moderate
High	4+	4+	High

<b>1. Number of Diagnosis &amp; Management Options</b>					
Category of Problem(s)	Occurrence of Problem(s)		Value		TOTAL
Self-limited or minor problem	(max 2)	X	1	=	
Established problem, stable or improved		X	1	=	
Established problem, minor worsening		X	2	=	
New problem with no additional workup planned or established patient with worsening of condition and no additional workup planned	(max1)	X	3	=	
New problem, additional workup planned or established patient with worsening of condition and additional workup planned.		X	4	=	
<b>2. Amount and/or Complexity of Data Reviewed</b>					
Date Type:					Points
Lab(s) ordered and/or reports reviewed					1
X-ray(s) ordered and/or reports reviewed					1
Discussion of test results with performing physician					1
Decision to obtain old records and/or obtain history from someone other than the patient					1
Medicine section (90701-99199) ordered and/or physical therapy reports reviewed and commented on progress (state whether the patient is progressing and how they are functionally progressing or not and document any planned changes to the plan of care)					2
Review and summary of old records and/or discussion with other health provider					2
Independent visualization of images, tracing or specimen					2
				TOTAL	

<b>3. Table of Risk (the highest one in any one category determines the overall risk for this portion)</b>			
Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Option(s) Selected
Minimal	One self-limited or minor problem, e.g., cold, insect bite, tinea corpori, minor non-sutured laceration	Lab tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis Ultrasound KOH prep	Rest Gargles Elastic bandages Superficial dressings
Low	Two or more self-limited or minor problems One stable chronic illness, e.g., well-controlled HTN, NIDDM, cataract, BPH Acute, uncomplicated illness or injury, e.g., allergic rhinitis or simple sprain Acute laceration repair	Physiologic tests nor under stress, e.g., PFTs Non-cardiovascular imaging studies w/contrast, e.g., barium enema Superficial needle biopsies Lab tests requiring arterial puncture Skin biopsies	Over-the-counter drugs Minor surgery w/no identified risk factors PT/OT IV fluids w/o additives Simple or layered closure Vaccine injection
Moderate	One of more chronic illnesses with mild exacerbation, progression or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis, e.g., new extremity neurologic complaints Acute illness with systemic symptoms, e.g., pyelonephritis, colitis Acute complicated injury, e.g., head injury with brief loss of consciousness	Physiologic tests under stress, e.g. cardiac stress test, Discography, stress tests Diagnostic injections Deep needle or incisional biopsies Cardiovascular imaging studies with contrast and no identified risk factors e.g. arteriogram, cardiac cath Obtain fluid from body cavity, e.g. lumbar puncture, thoracentesis, culdocentesis	Minor surgery with identified risk factors Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors Prescription drug management Therapeutic nuclear medicine IV fluids with additives Closed Tx of Fx or dislocation w/o manipulation Inability to return the injured worker to work and requires detailed functional improvement plan.
High	One or more chronic illness with severe exacerbation, progression or side effects of treatment Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others; An abrupt change in neurological status, e.g., seizure, TIA, weakness, sensory loss	Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors	Elective major surgery with identified risk factors Emergency major surgery Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis, Potential for significant permanent work restrictions or total disability Management of addiction behavior or other significant psychiatric condition Treatment plan for patients with symptoms causing severe functional deficits without supporting physiological findings or verified related medical diagnosis.

**Time Can Determine the Billed Level of E&M visit and level of service if greater than fifty percent (50%) of the provider's time at an E&M visit is spent either face-to-face with the patient counseling and/or coordination of care and there is detailed patient-specific documentation of the event(s).**

The total time spent face-to-face with the patient and/or coordination of care must be documented in the record along with the total visit time.

If time is used to establish the level of visit and total amount of time falls in between two levels, then the provider's time shall be more than half way to reaching the higher level.

Documentation must be patient specific and pertain directly to the current visit. Information copied directly from prior records without change is not considered current nor counted.

### **Counseling:**

The physician's time spent face-to-face with the patient and/or their family counseling him/her or them in one or more of the following:

1. Injury/disease education that includes discussion of diagnostic tests results and a disease specific treatment plan
2. Return to work
3. Temporary and/or permanent restrictions
4. Self-management of symptoms while at home and/or work
5. Correct posture/mechanics to perform work functions
6. Job task exercises for muscle strengthening and stretching
7. Appropriate tool and equipment use to prevent re-injury and/or worsening of the existing injury/condition
8. Patient/injured worker expectations and specific goals
9. Family and other interpersonal relationships and how they relate to psychological/social issues

10. Discussion of pharmaceutical management (includes drug dosage, specific drug side effects and potential of addiction /problems)
11. Assessment of vocational plans (i.e., restrictions as they relate to current and future employment job requirements)

**Coordination of Care:**

Coordination of care requires the physician to either call another health care provider (outside of their own clinic) regarding the patient's diagnosis and/or treatment, or the physician phones or visits the employer to safely return the patient to work.

The coordination of care activities must be done 24 hours *prior* to the actual patient encounter or within seven (7) business days *after* the patient encounter. If these activities are done outside these time frames, then Rule 18-5(l)(4) "Treating Physician Telephone or On-line Services" or Rule 18-6(A) "Face-to-Face or Telephonic meeting by a Treating Physician with the Employer ... With or Without the Injured Workers" is applicable.

**APPENDIX - Division Established Codes and Values (“Z”- codes) (for a complete list, please see the Director’s Interpretive Bulletin No. 13)**

<b>Rule Cite</b>	<b>Code</b>	<b>Description</b>
18-5(E)(2)(d)	Z0200	Upper Body w/Autonomic Stress Testing
	Z0201	Lower Body w/Autonomic Stress Testing
18-5(H)(4)	Z0500	Interdisciplinary Team
18-5(H)(6)	Z0501	Dry needling initial 15 min.
	Z0502	Dry needling - additional 15 min.
18-5(H)(8)	Z0503	Computer Enhanced Evaluation
	Z0504	Work Tolerance Screening
18-6(H)(11)	Z0505	Unattended Treatment fixed fee per day
18-5(I)(6)	Z0601	Face-to-face or telephonic meeting
18-6(A)	Z0701	Face-to-face or telephone meeting treating with Employer with report (SAMMS)
18-6(B)	Z0720	Cancellation Fee 1/2 usual fee or rate whichever is less
18-6(C)	Z0721	Copying Fee
18-6(R)	Z0722	Interpreter
18-6(E)	Z0723	Injured Worker’s Mileage
18-6(E)	70724	Injured Worker’s Other Travel Expense
18-6(D)(2)	Z0730	Prep Time Deposition and Testimony \$325.00/hr
18-6(D)(3)	Z0731	Deposition cancellation 7+
	Z0732	Deposition cancellation >5 but <7
	Z0733	Deposition cancellation <5
	Z0734	Deposition fee per hr
18-6(D)(4)	Z0735	Testimony cancellation 7+
	Z0736	Testimony cancellation >5 but <7
	Z0737	Testimony cancellation <5
	Z0738	Testimony Fee \$450.00/hr
18-6(F)(4)(b)	Z0759	Impairment Rating Treating Physician
	Z0760	Impairment Rating Referral
18-6(G)(2)(e)	Z0750	Initial WC 164
	Z0751	Progress Report
	Z0752	Closing Report
	Z0753	Initial and Closing on same report
18-6(G)(3)	Z0754	Completion addtl forms
18-6(G)(4)	Z0755	Special Report - Written Report or patient discharge letter required by § 8-43-404(10)(a), C.R.S.,
[ (G)(4) continues	Z0756	Special Report - IME/Report W Patient Exam
thru Z0767 below ]	Z0757	Special Report - Lengthy Form Completion
	Z0758	18-5(I)(7) Meeting & Report with Non-treating Physician
	Z0761	Special Report - cancellation not requiring patient exam
	Z0762	Special Report - IME/Report W Patient Exam Cancellation +7 days
	Z0763	Special Report - IME/Report W Patient Exam Cancellation >5 but <7 days

	Z0764	Special Report - IME/Report W Patient Exam Cancellation <5 days
	Z0766	CRS 8-43-404 IME Audio Recording
	Z0767	CRS 8-43-404 IME Audio Copying Fee
18-6 (G)(5)	Z0765	Opioid Management
18-6 (J)(6)(e)	G0378	Observation/convalescence
18-6 (K)(2)(d)	S9088	Urgent Care Facility Fee
18-6(L)(2)	S9123	Home Skilled Nursing
	S9122 & S9124	Home Certified Nurse Assistant
18-6(L)(4)	Z0772	Home Care Provider's Mileage
18-6(L)(5)	Z0773	Travel Time
18-6(M)(4)	Z0790 -0793	Compounded Drugs / Pharmacy
18-6 (O)(3)(b)	Z0800	LAc new patient
	Z0801	LAc established patient

# IMPAIRMENT

## AMA Guides 3<sup>rd</sup> Revised Edition

impairment – the loss of, loss of use of, or derangement of any body part, system or function.

disability - limiting, loss or absence of the capacity of an individual to meet personal, social, or occupational demands, or to meet statutory or regulatory requirements. (p. 251)

Activities of Daily Living should be permanently affected.

- self care and hygiene
- communication
- normal living postures
- ambulation
- travel
- non-specialized hand activities
- sexual function
- sleep
- social and recreational activities

## Colorado Revised Statute §8-42-101(3.7)

“A physician shall not render a medical impairment rating based on chronic pain without anatomic or physiologic correlation. Anatomic correlation must be based on objective findings.”

## Impairment Rating Tips

1. To receive an impairment for a spinal rating a patient with myofascial findings must first have “a minimum of six months of medically documented pain and rigidity with or without muscle spasm.”
2. For extremities any permanent change in range of motion may qualify for a rating.
3. Permanent nerve damage generally qualifies for a rating.
4. The AMA Guides provides for impairment rating based on surgery in many cases.

### **Isolated Mental Impairment (no physical injury)**

Pursuant to C.R.S. §8-41-301(2)(a), mental impairment “. . .consists of a psychologically traumatic event that is generally outside of a workers’ usual experience and would evoke significant symptoms of distress in a worker in similar circumstances. A mental impairment shall not be considered to arise out of and in the course of employment if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, promotion, termination, retirement, or similar action taken in good faith by the employer.”

# Codes of Ethics

*Note:* The Code of Ethics of the American Chiropractic Association as reproduced here may be found at the ACA's webpage, at [www.acatoday.com/content\\_css.cfm?CID=719](http://www.acatoday.com/content_css.cfm?CID=719)

Or, contact the American Chiropractic Association at 1-800-986-4636.

## **Code of Ethics**

### **PREAMBLE**

This Code of Ethics is based upon the acknowledgement that the social contract dictates the profession's responsibilities to the patient, the public, and the profession; and upholds the fundamental principle that the paramount purpose of the chiropractic doctor's professional services shall be to benefit the patient.

I. Doctors of chiropractic should adhere to a commitment to the highest standards of excellence and should attend to their patients in accordance with established best practices.

II. Doctors of chiropractic should maintain the highest standards of professional and personal conduct, and should comply with all governmental jurisdictional rules and regulations.

III. Doctor-patient relationships should be built on mutual respect, trust and cooperation. In keeping with these principles, doctors of chiropractic shall demonstrate absolute honesty with regard to the patient's condition when communicating with the patient and/or representatives of the patient. Doctors of chiropractic shall not mislead patients into false or unjustified expectations of favorable results of treatment. In communications with a patient and/or representatives of a patient, doctors of chiropractic should never misrepresent their education, credentials, professional qualification or scope of clinical ability.

IV. Doctors of chiropractic should preserve and protect the patient's confidential information, except as the patient directs or consents, or the law requires otherwise.

V. Doctors of chiropractic should employ their best good faith efforts to provide information and facilitate understanding to enable the patient to make an informed choice in regard to proposed chiropractic treatment. The patient should make his or her own determination on such treatment.

VI. The doctor-patient relationship requires the doctor of chiropractic to exercise utmost care that he or she will do nothing to exploit the trust and dependency of the patient. Sexual misconduct is a form of behavior that adversely affects the public welfare and harms patients individually and collectively. Sexual misconduct exploits the doctor-patient relationship and is a violation of the public trust.

VII. Doctors of chiropractic should willingly consult and seek the talents of other health care professionals when such consultation would benefit their patients or when their patients express a desire for such consultation.

VIII. Doctors of chiropractic should never neglect nor abandon a patient. Due notice should be afforded to the patient and/or representatives of the patient when care will be withdrawn so that appropriate alternatives for continuity of care may be arranged.

IX. With the exception of emergencies, doctors of chiropractic are free to choose the patients they will serve, just as patients are free to choose who will provide healthcare services for them. However, decisions as to who will be served should not be based on race, religion, ethnicity, nationality, creed, gender, handicap or sexual preference.

X. Doctors of chiropractic should conduct themselves as members of a learned profession and as members of the greater healthcare community dedicated to the promotion of health, the prevention of illness and the alleviation of suffering. As such, doctors of chiropractic should collaborate and cooperate with other health care professionals to protect and enhance the health of the public with the goals of reducing morbidity, increasing functional capacity, increasing the longevity of the U.S. population and reducing health care costs.

XI. Doctors of chiropractic should exercise utmost care that advertising is truthful and accurate in representing the doctor's professional qualifications and degree of competence. Advertising should not exploit the vulnerability of patients, should not be misleading and should conform to all governmental jurisdictional rules and regulations in connection with professional advertising.

XII. As professions are self-regulating bodies, doctors of chiropractic shall protect the public and the profession by reporting incidents of unprofessional, illegal, incompetent and unethical acts to appropriate authorities and organizations and should stand ready to testify in courts of law and in administrative hearings.

XIII. Doctors of chiropractic have an obligation to the profession to endeavor to assure that their behavior does not give the appearance of professional impropriety. Any actions which may benefit the practitioner to the detriment of the profession must be avoided so as to not erode the public trust.

XIV. Doctors of chiropractic should recognize their obligation to help others acquire knowledge and skill in the practice of the profession. They should maintain the highest standards of scholarship, education and training in the accurate and full dissemination of information and ideas.

The ACA's Code of Ethics was revised and ratified by the ACA House of Delegates September 2007.



AMERICAN COLLEGE OF  
OCCUPATIONAL AND  
ENVIRONMENTAL MEDICINE

## ***The Seven Ethical Principles of Occupational and Environmental Medicine***

***Occupational and environmental health professionals have an obligation to...***

### ***1. Promote a Safe and Healthy Workplace Environment***

Acknowledge primary responsibility for the health and safety of the individual, as well as worker populations, and take affirmative measures to ensure health and safety in the workplace.

### ***2. Uphold Ethical Standards***

Behave honestly and ethically in all professional relationships, actively resisting and striving to correct unethical conduct. Recognize and acknowledge impairments that interfere with the ability to follow this Code and take appropriate measures to ameliorate them and restricting practice until remediation is accomplished.

### ***3. Avoid Discrimination***

Build a relationship of trust and confidence with the people for whom they provide services, treating all in an equitable manner, without any form of discrimination. Identify and overcome bias or stereotypes which may affect medical care and decision making both in individual patients and in the populations served.

### ***4. Maintain Professional Competence***

Maintain individual competence and expertise based on current scientific evidence and technical knowledge, remaining engaged in life-long learning regarding work and the environments of those whom they serve and applying appropriate methods to eliminate or minimize risks and recognizing when to call upon specialized expert advice.

### ***5. Protect Patient Confidentiality***

Keep confidential all individual medical, health promotion, and health screening information, only releasing such information with proper authorization. Recognize that employers may be entitled to counsel about an individual's medical work fitness.

### ***6. Advise and Report***

Communicate effectively and in a timely manner to an individual all significant observations about the health and health risk of that person and provide advice about interventions available to restore, sustain, and improve health or prevent illness. While respecting confidentiality, report findings and observations of health effects in individuals and populations to those in a position to take appropriate action.

### ***7. Address Conflict of Interest***

Ensure ethical conduct regarding conflicts of interest by recognizing, acknowledging, and appropriately addressing any secondary interests that might in reality distort the integrity of judgments or be perceived to do so. Ethical practice must ensure that harm does not accrue as a result of such conflicts.

*Approved by the ACOEM Board of Directors, April 2010*

# Confidentiality of Medical Information in the Workplace

Tuesday, November 06, 2012

## ACOEM Committee on Ethical Practice in Occupational and Environmental Medicine

As do all physicians, occupational and environmental medicine (OEM) practitioners rely on the patient to completely and truthfully disclose private information before rendering a professional opinion. In order to facilitate the disclosure of private personal information, employees must feel that their private disclosures will be treated in a dignified and confidential manner. Because a physician must first of all do no harm, information received in confidence should be disclosed only when it is in the best interests of the patient or society, or required by applicable law or valid governmental rule or regulation.

When considering requests for job accommodation, addressing threats to health or safety, or reviewing claims for workers' compensation benefits, employers may require access to personal information. Additionally, employers shoulder an increasing responsibility for providing other types of benefits such as health and disability insurance, family medical leave, and employee assistance programs. As a result, the employer becomes inextricably and unavoidably involved in employees' personal and medical affairs. Thus, competing interests between the employee's right to privacy and the employer's legitimate interest in the health of the employee creates sensitive ethical and legal dilemmas for physicians who practice occupational medicine. Other parties, such as insurers, state and federal agencies, and accrediting organizations may also have a right to patient records, and this right must be considered and managed carefully.

The laws governing the confidentiality of employee medical information are complex and vary depending on the relationship between parties and by jurisdiction.<sup>1</sup> Difficult ethical problems arise when the physician must attempt to balance the importance of the employee's need and legal right to keep information confidential versus the employer's need and legal right to know or the interests of other parties.

### ACOEM Position

The American College of Occupational and Environmental Medicine (ACOEM) acknowledged the importance of medical confidentiality with publication of its first Code of Ethical Conduct in 1976. This Code was later revised in 1993 to reflect changes in the character of the modern workplace,<sup>2</sup> and subsequently updated in 2010.<sup>3</sup> The 2010 Code of Ethics states that physicians should:

"5. Protect Patient Confidentiality. Keep confidential all individual medical, health promotion, and health screening information, only releasing such information with proper authorization. Recognize that employers may be entitled to counsel about an individual's medical work fitness."<sup>3</sup>

### Additional Guidance on Medical Confidentiality in the Workplace

While the ACOEM Code of Ethics provides direction, the ACOEM Committee on Ethical Practice in Occupational and Environmental Medicine believes that additional guidance on the issue of confidentiality is necessary. Therefore, in addition to Point 5 of the ACOEM Code of Ethics, the College is providing the following guidance regarding medical record confidentiality:

1. Legislation and local practice may treat medical records created in the context of occupational health, independent medical evaluations, and workers' compensation cases differently from medical records created by personal health care providers. However, the physician practicing occupational medicine is advised not to make such distinctions in practice without clear legal guidance or permission from the proper parties. Confidential medical information should be treated the same as in situations where there is a clear physician-patient relationship unless there is a valid legal reason or consent to do otherwise, a health and safety risk to the client or others, or evidence of a criminal act.<sup>4</sup>
2. Physicians should make all reasonable efforts to obtain the patient's consent before disclosing all or any portion of his or her medical record. If disclosure is legally required or consent is not legally required, the patient should be notified of the impending disclosure unless such notification is impossible or there are overriding patient or public health concerns.
3. Physicians should recognize a patient's consent-for-disclosure only if said consent is both informed and voluntary. The consent should specify the nature of the information to be released, the purposes for its release, the person or persons to whom it may be released, the time period for which the consent remains in effect, and acknowledgement statement that the patient may rescind consent at anytime. The consent must be signed by the employee or his or her legal guardian, or if the employee is deceased, by his or her personal representative.
4. Whenever physicians are aware that the results of an examination or records of a visit may be shared with a third party (e.g., in the case of an independent medical examination the information will be shared with an insurer and/or attorneys representing the insurer and the claimant), it is incumbent upon the physician to properly notify the examinee prior to gathering historical or clinical data as to the nature of the evaluation, what information will be collected, and to whom it will be transmitted. The physician should not state or imply that any records will be kept confidential if this cannot be assured. The physician performing independent medical examinations should be knowledgeable of statutes and/or regulations controlling the distribution of their reports. It is appropriate that the insurer and physician share with the claimant the nature of information to be included and the distribution of the report. Sensitive confidential medical information that is not relevant to the claim should not be included in the report.
5. Although all personal health information should be presumed to be confidential, physicians should recognize that certain types of health information are particularly sensitive such as sexual orientation, HIV/AIDS status,<sup>5</sup> drug and alcohol treatment, past history of physical or sexual abuse, treatment for sexually transmitted diseases, and genetic information.<sup>6</sup> Physicians should be aware that a general consent for disclosure of medical records cannot be presumed to be sufficient in these situations and that specific written consent for release of such information must be obtained. This information should only be

disclosed in compliance with U.S. federal and state law and similar laws of other countries where occupational physicians work. Because it is often possible to infer sensitive information from other parts of the medical record, such as the medication history, the physician should treat such information in the same manner as explicitly sensitive information.

6. Physicians should release only the portion of a record covered by a release and not disclose the entire medical record unless indicated and permitted by the patient. Forwarding records that have been obtained from other medical providers is appropriate when that information is relevant to the specific problem in question and permitted.

7. Physicians should develop a written policy for the treatment of medical records in their offices, clinics, or workplaces. The policy should address such issues as where, and for how long the records are stored; the security of medical records including computer databases; what happens in the event of employee resignation, layoff, termination, job transfer, or closure and/or merger of employer; and the mechanisms of employee access and consent for disclosure.<sup>7</sup>

8. Physicians should make reasonable efforts to ensure that those under their supervision act with due care regarding the confidentiality of medical records, and act to educate fellow health care providers and office support staff regarding the confidentiality of medical information. Physicians should encourage the confidential treatment of medical information by their clients and in their organization by colleagues in other departments such as human resources or benefits who may have access to such data.

9. Physicians should disclose their professional opinion to both the employer and the employee when the employee has undergone a medical assessment for fitness to perform a specific job. However, the physician should not provide the employer with specific medical details or diagnoses unless the employee has given his or her permission. Additionally, physicians should not disclose without permission any “non-medical” information gained in the context of a physician/patient relationship that could adversely affect the employee. Exceptions include health and safety concerns or knowledge of unlawful activity.

10. Physicians should notify employees of their right to obtain access to their medical records and to request correction of any inaccuracies therein.<sup>8</sup>

11. Supervisors and managers may be informed regarding necessary restrictions on the work or duties of the employee and recommended accommodations. First aid and safety personnel may be informed, when appropriate, if a condition might require emergency treatment, in which case the employee should be informed.

12. Physicians should be a source of professional, unbiased, and expert opinion in the workers’ compensation or court systems and should only disclose medical information that is relevant and necessary to the claim or suit. When release of medical information is authorized or required by specific regulation, only the necessary and relevant information should be released.

13. Physicians should exercise caution whenever presented with a request or subpoena for medical records that does not include a written authorization for release by the employee, or when the records requested contain information about HIV status, drug and alcohol

treatment, or genetic information. It may be appropriate to seek legal advice in these situations.

14. Physicians should withdraw or decline services when faced with an irresolvable ethical conflict or an unethical request by a client or employer. In many instances, the medical record will be the property of an employer. This ownership does not abrogate any of these principles. Each employer that owns medical records should designate a custodian of the records. Access by employer officials (e.g., employee relations, legal counsel) should proceed via the same process as requests by those outside the employer through the custodian. Physicians should consider inquiring about the employer's practices regarding medical records prior to employment or contractual services.

Because OEM physicians work in a wide variety of practice situations and must respect the laws and customs of many countries, physicians have an ethical duty to become familiar with laws and regulation applicable to their practice. The College believes that all employee health and medical records should be treated as confidential by the employer and provider; however, occupational medicine physicians are in a unique position and must carefully balance the interests of all parties and society as a whole. These recommendations are intended to serve as guidance for OEM physicians in their relationships with their patients and the other individuals that they serve including employers.

#### References

1. Rischitelli DG. The confidentiality of medical information in the workplace. *J Occup Environ Med.* 1995;37(5):583-93.
2. Teichman R, Wester MS. Code of ethical conduct. *J Occup Med.* 1994;29(1):27-30.
3. ACOEM Code of Ethics. 2010. Available at [www.acoem.org/codeofconduct.aspx](http://www.acoem.org/codeofconduct.aspx).
4. American Medical Association Council on Ethical and Judicial Affairs. *Code of Medical Ethics. Current Opinions with Annotations.* Chicago, Ill: AMA, 2006.
5. Americans with Disabilities Act, 42 USC §12112(D)(3)(B) (1990).
6. ACOEM Task Force on Genetic Screening in the Workplace. Position statement. Genetic screening in the workplace. *J Occup Environ Med.* 2010;52(7):763. Available at [www.acoem.org/GeneticScreening.aspx](http://www.acoem.org/GeneticScreening.aspx).
7. Health Insurance Portability and Accountability Act of 1996 (HIPAA). *Federal Register.* 65 FR 82462. December 28, 2000. Available at [www.hhs.gov/ocr/hipaa/finalreg.html](http://www.hhs.gov/ocr/hipaa/finalreg.html).
8. OSHA. Access to Employee Exposure and Medical Records Standard. 19 CFR § 1910.20.

This statement was reviewed and revised by the ACOEM Committee on Ethical Practice in Occupational and Environmental Medicine. Committee members are Drs. David Lukcso, chair, Paul Brandt-Rauf, and William W. Greaves. This statement was peer-reviewed by Dr. Robert Orford, and approved by the ACOEM Board of Directors on July 28, 2012. This statement updates ACOEM's 2008 statement.

These Interprofessional Guidelines are endorsed by the Colorado Bar Association, Denver Bar Association, Colorado Medical Society and Denver Medical Society (2013).  
<http://www.cobar.org/index.cfm/ID/20100/subID/28380/CITP//>

## **Colorado Interprofessional Guidelines**

### **1. Purpose**

1.1. The Colorado Interprofessional Code is designed to guide relations between attorneys and health care professionals in client/patient matters. Such interactions are best facilitated when the two professions understand the responsibilities of the other and work together with cooperation and mutual respect.

1.2. Health care professionals must understand that medical testimony is often necessary in court proceedings. Hence, health care professionals should engage in the legal process in a professional and responsible manner that demonstrated respect for an attorney's duties, role, and circumstances, as well as the needs and rights of their patients.

1.3. Legal professionals have a corresponding duty to engage a health care professional in a professional and responsible manner that demonstrates respect for the health care professional's duties, role and circumstances. Recognizing that a health care professional's primary obligation is to provide patient care, efforts should be made to minimize disruption to the professional, patients, and the practice.

### **2. Medical/Legal Dispute Resolution Sub-Committee**

The Committee will be comprised of members of the plaintiff's bar, members of the defense bar (who are members of the Bar Associations' Interprofessional Committee), and members/ staff of the medical society. The subcommittee will be co-chaired by one member of the Bar Association and one member of the Medical Society.

### **3. Release of Medical Records**

3.1. A health care professional or institution should not release medical records without a patient authorization or a court order, unless there is some statutory exception that allows the release of the records (i.e. child abuse, coroner investigation, etc.). A subpoena for records must contain a valid authorization. A health care provider who is unsure about the proper lawful authority should contact his or her attorney or medical malpractice provider.

3.2. A party or attorney issuing a subpoena on a health care professional/institution or custodian will take reasonable steps to avoid imposing undue burden or expense.

### **4. Scheduling**

4.1. Attorneys should schedule the services of a health care professional far enough in advance and in such a manner to minimize inconvenience and disruption to the professional, patients and the practice. Attorneys should advise health care professionals or trial or hearing

dates at the time the trial or hearing is set and promptly inform health care professionals of any schedule modifications.

4.2. Attorneys should communicate, to the extent possible, the nature and subject of the subpoena. Services of a subpoena should be scheduled to minimize the inconvenience to the health care professional and limit disruption to patients and the practice.

## **5. Fees for Services**

5.1. Health care professionals may charge a reasonable fee for services whether the professional is providing services as a treating witness or as a specially retained witness. The attorney and health care professional should have a formal written agreement before services are provided.

5.2. In general, a health care provider should charge for medical/legal services what he or she would have likely earned during the time required for the health care provider to render the testimony or other services being requested. Workers' Compensation, governmental, or agency guidelines or regulations may set fee schedules with legal limits.

5.3. If scheduled medical testimony is canceled or postponed, the health care professional may be entitled to compensation depending on the timeliness of notice and amount of disruption to the professionals' practice. Health care professionals are encouraged to use time made available after reasonable notice of cancellation. Cancellation fees should be addressed in advance as part of the written agreement between the attorney and the health care professional.

5.4. Whenever document review, medical reports, conference, or medical testimony are requested by an attorney, it will be conclusively presumed that the attorney has made definitive arrangements with the client for payment of all reasonable charges and that the attorney will be responsible for payment to the health care professional. The health care professional should be aware that the client/patient, not the attorney, is ultimately responsible for reimbursement to the attorney.

5.5. A health care professional should submit an itemized bill to the attorney for services. The attorney is accountable for promptly compensating the health care professional for the services provided. Medical rules of ethics prohibit fees for medical testimony from being contingent upon the outcome of litigation.

## **6. Scope of Services**

6.1. Although health care professionals are "expert witnesses" because of their experience and training, a distinction is made between health care professionals who testify based upon and about facts gained from personal observation of a patient (treating expert witness), and professionals who give opinions based upon facts furnished to them for review in the course of litigation outside their direct care and treatment of the patient (specially retained expert witnesses).

6.2. Attorneys may request a health care professional to testify as a specially retained expert witness to give opinions beyond the facts gained from personal treatment of a patient (e.g. the

appropriateness of another professional's care, hypothetical situations, etc.). The decision to do so is solely within the discretion of the health care professional. A treating health care provider is not obligated to render an opinion outside the scope of his care and treatment.

## **7. Dispute Resolution**

Health care professionals and attorneys should promptly submit a summary of any dispute along with supporting documentation to the Interprofessional Committee at:

Interprofessional Committee  
Colorado Bar Association/Denver Bar Association  
1900 Grant St., Suite 950  
Denver, CO 80203-4309

Or:

Interprofessional Committee  
Colorado Medical Society  
7351 Lowry Blvd.  
Denver, Colorado 80230

## **8. Notice**

Once a dispute is submitted, the parties will receive a written communication from the Committee. Member(s) of the Committee will investigate the dispute and make recommendation(s) for resolution. The full committee will review the recommendation(s) and issue a final written opinion. The Committee's recommendation(s) is not binding unless agreed to by the parties.

## ELEMENTS OF A QUALITY WORKERS' COMPENSATION REPORT

1. **Identify patient and referral sources;** e.g., employer referred for first time evaluation, patient referred self without contacting employer, referred by an authorized treating physician.
2. **Specify any additional sources of information reviewed;** e.g., employer job description, x-ray or lab tests, and other medical records.
3. **Record patient's history**
  - Chief complaint
  - Details of accident or exposure
  - Occupation and job duties
  - Current functional status (work related and activities of daily living)
  - Pre-existing injuries, disease and functional status
4. **Record physical exam** - Pertinent negatives are important so be sure to examine related body regions based on mechanism of injury.
5. **Describe behavioral exam when appropriate** - Always assess for signs of depression in patients with chronic pain or delayed recovery.
6. **Note any diagnostic tests** ordered and their results if known.
7. **List diagnoses** – Be specific and use ICD-9 classification. Cumulative trauma or repetitive motion is not a diagnosis!
8. **Discuss work relatedness for each diagnosis.** State your opinion as to the medical probability (greater than 50%) that the diagnosis was caused by a work accident or job duties.
9. **Describe treatment plan** - Include expected functional goals, specific length of treatment and frequency. If treatment is outside of the Colorado Medical Treatment Guidelines justify the necessity for treatment with specific functional goals.
10. **Provide detailed work and activity restrictions.** Factors to consider:
  - Posture - sitting, standing, kneeling, etc.
  - Lifting - specify waist level, overhead, repetitive
  - Repetitive movements – keyboarding, writing, pinching, tool use
  - Hot or cold environments
  - Special tasks - driving, climbing ladders, assembly line work
11. **Describe patient education provided.** Examples:
  - Self management – e.g. application of heat or cold
  - Exercises
  - Detailed explanation of activity limitation and progression
  - Natural course of condition and expected outcome.
12. **Record expected date of next visit and any specific referrals made.**

## **Psychological Screening**

Examples of brief psychological screening exams follow; not included in this copy. You may contact the Division's Physicians' Accreditation Program for copies of these documents.

## **EXPEDITED HEARING**

As noted in the discussion on denial of prior authorization, the patient may approach the Division of Administrative Hearings to request an expedited hearing when there is an urgent need for prior authorization for health care services.

Attached is a copy of the required form.

(Copy of Office of Administrative Courts form “Application for Expedited Hearing” is referenced but is not included here.)

## **Timely Payment Issues**

## MOST COMMON TIMELY MEDICAL PAYMENT ISSUES

### Workers' Compensation Health Billing Payment and Dispute Resolution Process Effective January 1, 2013

ISSUE	PROCESS	APPLICABLE RULE/DOWC COMMENT
	<b>PRIOR AUTHORIZATION OF SERVICES</b>	
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. Providers may use Division Form #188 available on the Department website.	Rule 16-9(F)
Denial of prior authorization	All denials of prior authorization must be in complete compliance with Rule 16-10	Rule 16-10(E) - allows for automatic authorization if denial is not done timely. Rule 16-10(F): Unreasonable denial may lead to penalties.
	<b>PRIOR TO SUBMITTING BILLS</b>	
Duplicate or inaccurate bills	Before sending the bill, the provider should verify the billed information on the CMS 1500 to insure the fields are properly filled out and the information is correct.	
Late Billing	The provider must bill within 120 days of the date of service.	Rule 16-7(F)
Specialty not identified on bill	Bill for only one provider per CMS 1500 form. Field 31 of the CMS 1500 may be used to identify the supervising provider, and field 24J used to identify the provider rendering the treatment, if different than the supervising provider.	
Late submission of notes and supporting documentation	The Division recommends submitting all billing documentation at the time of submitting the bill unless a private	See Rule 16-7(E), Required Billing Forms and Accompanying Documentation, for rules concerning the submission of initial, interim and closing medical

ISSUE	PROCESS	APPLICABLE RULE/DOWC COMMENT
Hospitals are charging for copies of records	The payers 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.	Rule 16-7(E)(3)
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 16-11(H)
No acknowledgment of receipt of bill	<b>REVIEW AND PROCESSING OF BILLS</b>	Rule 16-11(A)(2) and Division recommendation
	Within thirty (30) 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. (The claimant can proceed with their own claim if the employer has not filed.)	C.R.S. 8-42-101(4) Worker may use form WC15, “Worker’s Claim for Compensation,” available on the Division’s webpage <a href="http://www.colorado.gov/cdle/dwc">www.colorado.gov/cdle/dwc</a> Click on “Official Forms, Publications and Interpretive Bulletins”
Second request for medical records	Payer internal documentation routing should not require a second request for documentation and/or a bill going unpaid.	Any second request for medical records by the payer should generate a copying fee billed by the provider and paid by the payer. (Rule 18-6(G)(1))
	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 16-11(A)

Down-coding or changing of codes	<p>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, unless the provider agrees. The provider has 60 days to resubmit the denied codes and modifiers with additional information.</p> <p>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.</p>	<p>Rule 16-11(B) and (C)</p> <p>Rule 16-11(D)</p>
<b>PAYMENT OR DENIAL OF PAYMENT RECEIVED</b>		
Re-review of claims	<p>The provider has 60 days to contest reasons for non-payment and present their argument</p> <p>Payer has thirty (30) days from receipt of resubmission to pay or explain continued denial.</p>	<p>Rule 16-11(D)(1)</p> <p>Rule 16-11(D)(3) &amp; (4)</p>
Retroactive Audits	<p>Recovery of overpayments to providers must be within 12 months after the date of the original explanation of benefits.</p>	<p>Rule 16-11(F)</p>
<b>DISPUTE RESOLUTION</b>		
Disputes	<p>In the event of continued disagreement, the parties should follow dispute resolution procedures available through the Division's Medical Policy Unit. Disputes must be initiated by using Division Form #181 available on the Department website.</p> <p>Unresolved disputes may follow the procedures in Rule 9 or through the Office of Administrative Courts.</p>	<p>Rule 16-11(E)</p>

## **MISC. REFERENCE MATERIALS**

The materials in this section are for your use and reference only. You will *not* be tested on any of these materials.

(The reader may contact the Division's Physicians' Accreditation Unit for a copy of these materials. Some are not in an electronic format.)