

CHRONOLOGY OF A WORKERS' COMP CASE

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 (defined under the statute as an M.D., D.O., chiropractor, podiatrist, or dentist). The claimant is presented with a list of at least two physicians, two clinics, or combination thereof, from which the worker must choose a primary treating physician. If the employer does not timely designate a list of two 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. 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.

§8-42-106(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.

§8-42-105(3), C.R.S.

Complete the WC164 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.

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 completes WC164 form (“Physician’s Report of Workers’ Compensation Injury”) and submits to insurer and patient.

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 3rd 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