COLORADO DEPARTMENT OF REGULATORY AGENCIES
OFFICE OF POLICY AND RESEARCH

COLORADO WORKERS' COMPENSATION ACCREDITATION PROGRAMS AND ACCREDITATION COMMISSION

1995 SUNSET REVIEW

Joint Legislative Sunrise/Sunset Review Committee
1995-1996 Members

Senator Richard Mutzebaugh
Chair

Senator Ginette Dennis
Senator Bob Martinez
Representative Alice Nichol
Representative Penn Pfiffner
Representative Mike Salaz

Department of Regulatory Agencies Staff

Joseph A. Garcia
Executive Director

H. Rene Ramirez
Director, Office of Policy and Research

Bruce Harrelson
Senior Policy Analyst

Polly Nolin
Authoring Analyst

June 30, 1995

The Honorable Richard Mutzebaugh, Chair
Joint Legislative Sunrise/Sunset Review Committee
State Capitol Building
Denver, Colorado 80203

Dear Senator Mutzebaugh:

The Colorado Department of Regulatory Agencies has completed the evaluation of the **Workers' Compensation Accreditation Programs and Accreditation Commission**. We are pleased to submit this written report, which will be the basis for my office's oral testimony before the Joint Legislative Sunrise/Sunset Review Committee. The report is submitted pursuant to §24-34-104 (8)(a), of the Colorado Revised Statutes, which states in part:

> *"The Department of Regulatory Agencies shall conduct an analysis of the performance of each division, board or agency or each function scheduled for termination under this section...*
>
> *The Department of Regulatory Agencies shall submit a report and such supporting materials as may be requested, to the Sunrise and Sunset Review Committee created by joint rule of the Senate and House of Representatives, no later than July 1 of the year preceding the date established for termination..."*

The report discusses the question of whether there is a need for the regulation provided under article 42 of title 8, C.R.S. The report also discusses the effectiveness of the division and staff in carrying out the intention of the statutes and makes recommendations for statutory and administrative changes in the event this regulatory program is continued by the General Assembly.

Sincerely,

Joseph A. Garcia
Executive Director

Table of Contents

EXECUTIVE SUMMARY

The Department of Regulatory Agencies has concluded its Sunset Review of the Workers' Compensation Accreditation Program and the Medical Care Accreditation Commission, and recommends the continuation of both.

In an effort to reform Colorado's workers' compensation system and bring its rising costs under control, the General Assembly passed SB 91-218 in 1991. The legislature hoped to elevate the proficiency level of medical care providers who worked within the workers' compensation system, thus reducing the problems that the system had been experiencing.

This report explains the accreditation process and the responsibilities of the commission. It also examines their growing acceptance throughout the workers' compensation community. This report also discusses the concerns that some have expressed about both programs.

The conclusion this review reaches is that as long as the current workers' compensation benefit structure is continued, both the accreditation program and the medical care accreditation commission need to be continued. They are integral parts of the total medical cost containment program.

BACKGROUND

History of Colorado Workers' Compensation

Colorado passed a workers' compensation law in 1915 making it one of the first states to do so. The law has been amended many times since its inception, but the policy behind it remains the same. Compensation for work related injury and illness depends upon the employee-employer relationship, not upon provable negligence attributable to the employer.

Throughout its history, Colorado's workers' compensation system has been controversial and adversarial. Prior to 1991, employers complained that the workers' compensation system was too costly while workers' representatives claimed that inadequate benefits were being paid to the injured. Between 1980 and 1990, employers experienced approximately a 12 percent annual increase in premiums. In 1991, the National Council on Compensation Insurance ("NCCI") petitioned for a rate increase of 38 percent. Because of the continuing increase of workers' compensation premiums, the economic community of Colorado feared that businesses would leave or would not locate in the state.

In response to these concerns, the legislature passed SB 91-218 which completely revised Colorado's workers' compensation benefit structure. It also created a new Division of Workers' Compensation ("Division") located in the Department of Labor. In the new law, the legislature declares:

> *It is the intent of the general assembly that the "Workers' Compensation Act of Colorado" be interpreted so as to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation, recognizing that the workers' compensation system in Colorado is based on a mutual renunciation of common law rights and defenses by employers and employees alike. §8-40-102(1), C.R.S.*

To achieve this objective, in part, the amended statute created a new system by which permanent partial disability is determined. In fact, the term “permanent disability” is no longer the appropriate term to describe the result of an injury to a worker. The correct term is “permanent medical impairment.” These terms are not synonymous. The *American Medical Association, Guides to the Evaluation of Permanent Impairment* (3d ed. 1988) defines **medical impairment** as an alteration of the individual’s health status assessed by medical means. **Disability** is defined as an alteration of an individual’s capacity to meet personal, social, or occupational necessities, as well as any state regulatory requirements.

The permanent medical impairment designation is determined exclusively on the basis of a medical evaluation. No other factors, such as economic loss, are considered when determining benefits. Historically, permanent partial disability benefits were decided by a judge and based on the loss of the injured workers’ earning capacity.

Because of this shift in the focus on how an impairment of an injured worker is determined, the role of the primary treating physician has changed dramatically. Under the old system, the evaluation by the physician was only one component in determining disability benefits. In making this determination, a judge could consider many factors, such as the claimant’s physical limitation, age, education, and previous job experience, in addition to a physician’s evaluation.

Under the new law, permanent partial impairment is determined by one of two methods. One method uses a statutory schedule which lists specific injuries. It is used when the injury is limited to a body extremity. The other method is used when an injury results in permanent medical impairment and the injury is not listed in the schedule. In these instances, the injury is considered to be to the “whole person,” and the medical impairment benefits are determined by using a statutory formula.

The section of the statute that lists scheduled injuries is not subject to this review.

SUMMARY OF STATUTE

Two subsections of the statute are under review. These are §§8-42-101(3.5) and (3.6), C.R.S.. These subsections mandate the creation of the Medical Care Accreditation Commission and Level I and Level II Physician Accreditation programs.

Level I and Level II Accreditation (3.6)

Level I accreditation educates physicians who treat workers with injuries that result in more than three days of lost time - known as a "time loss injury." The primary objective of Level I accreditation is to familiarize providers on medical guidelines, and the administrative and legal aspects of workers' compensation. The accreditation is voluntary for physicians, podiatrists, and dentists. It is mandatory for chiropractors. A chiropractor may treat a worker with a time loss injury without being Level I accredited if the patient is not seen for more than 12 times or for more than 90 days, whichever comes first.

Level II accreditation is mandatory for any physician who wants to perform medical impairment ratings on workers. The program educates physicians on how to do impairment ratings as well as instructing them on the medical guidelines, and administrative and legal issues. The primary objective of Level II accreditation is to standardize the medical impairment rating process. Only physicians licensed under the "Colorado Medical Practice Act" (M.D.'s and D.O.'s) may become Level II accredited. If physicians are accredited under Level II, they do not also have to be Level I accredited.

Accreditation for both levels is valid for three years and may be renewed for successive three year periods.

The Division is required to charge enough in registration fees for the accreditation programs to cover the cost of the course work and materials provided. The statute also imposes a registration fee cap of $250.00 for Level I accreditation and $400.00 for Level II accreditation.

The Division may revoke an accreditation for "good cause shown" as defined in rule. The medical director may make recommendations to the Director as to revocation, and there must be a hearing before an Administrative Law Judge ("ALJ") in order to revoke a providers accreditation.

Medical Impairment Ratings and Statutory Schedule

The sections of the statute that directs the Division on how to calculate benefits for permanent partial disability are not subject to this review; however, they will be discussed in order to explain the accreditation program and the responsibilities of the Medical Care Accreditation Commission ("MCAC").

Only Level II accredited physicians may do medical impairment ratings. A medical impairment rating is important because it is an essential component of calculating what dollar benefit a worker receives for permanent partial disability . There are potentially two methods under which benefits may be calculated.

The first method is compensation under "scheduled injuries." These injuries are listed in the statute. When an injury results in permanent medical impairment, and the employee has an injury enumerated in the schedule set forth in the statute, the employee is limited to the medical impairment benefits allowed under that schedule. It lists 38 potential injuries with a corresponding number of weeks assigned to each injury. For example, if a foot is amputated below the ankle, the worker would receive 104 weeks of benefits at the rate of $150.00 per week.

The second method is used if an injury is not listed in the schedule. Instead, the worker is compensated based on a "whole person" impairment rating. First, the authorized treating physician determines when the employee reaches maximum medical improvement. Second, when the date of maximum medical improvement is determined, the authorized treating physician determines a medical impairment rating as a percentage of the whole person. This impairment rating is based on the *American Medical Association Guides to the Evaluation of Permanent Impairment 3rd edition revised* ["*AMA Guides* (3rd ed. revised)]. Third, the insurance adjuster then determines the medical impairment benefits by

(1) multiplying the medical impairment rating, to

(2) an age factor listed in the statute, and

(3) 400 weeks.

Only an authorized treating physician may determine a "whole person" medical impairment rating. This means that authorized treating physicians must be Level II accredited in order to do medical impairment ratings. Because a physician who treats workers with time loss injuries does not have to be Level II accredited, or even Level I for that matter, it is possible that a medical impairment rating would have to be done by an Independent Medical Examiner ("IME"), a Level II accredited physician consultant, or a Level II accredited Authorized Treating Physician ("ATP").

When this situation occurs, the workers' compensation carrier must either request a Division independent medical examination in order to ascertain a claimant's medical impairment, or enter into an agreement with the claimant as to which IME will do the impairment rating. It remains to be decided if the authorized treating physician may refer the claimant to a Level II accredited physician. There has been a recent decision by the Industrial Claim Appeals Panel ("ICAP"),[Mungia v. Canam Industries, Inc, W.C. No. 44-151-268, Dec. 16, 1994], which concluded that under current law, ATPs could not refer a claimant to a Level II accredited physician for a medical impairment rating. Subsequent to that decision, the Division has passed a rule that allows ATPs to refer claimants to a Level II accredited physician for a medical impairment rating. At this time, the Division does not know if the rule or case law is controlling.

The statute requires the Division to promulgate rules that establish a system for determining medical treatment guidelines, utilization standards, and medical impairment rating guidelines based on *AMA Guides* (3rd ed. revised). The MCAC's role is to advise the Division on the formulation of these rules.

Medical care Accreditation Commission (3.5)

DUTIES AND RESPONSIBILITIES OF THE COMMISSION

The Medical Care Accreditation Commission ("MCAC") was created to help the Division develop mechanisms necessary to implement parts of the workers' compensation law. More specifically, its directive is to advise the Director of the Division of Workers' Compensation on the following matters:

1. the fee schedule for which all medical, surgical, hospital, dental, nursing, and vocational rehabilitation treatment rendered to employees under §8-42-101, C.R.S. shall be compensated,

2. medical impairment rating guidelines,

3. medical treatment guidelines,

4. utilization standards, and

5. denial of surgery and its relationship to maximum medical improvement.

MAKEUP OF THE COMMISSION

The makeup of the 7 member commission and 1 ex-officio member is:

- Two members must be physicians licensed in Colorado,
- One member must be a chiropractor licensed in Colorado,
- Two members must be consumers,
    - ◊ 1 consumer member must represent small business interests,
    - ◊ 1 consumer member must represent risk management interests,
- One member must represent workers injured on the job,
- One member must represent insurance industry interests,
- The medical director serves as an ex-officio member, and acts as an advisor to the commission. The statute requires that the medical director come from the University of Colorado Medical School.

QUALIFICATIONS BY PHYSICIAN COMMISSION MEMBERS

The physicians on the commission must meet the following specific professional qualifications:

1. a minimum of 3 years experience in occupational medicine with 30% of the physician's practice devoted to cases involving occupational injuries, or

2. a minimum of 5 years experience in occupational medicine with 15% of the physician's practice devoted to cases involving occupational medicine.

The balance of the physicians' practice may consist of any type of medicine.

REMOVAL FROM COMMISSION

The governor may remove a commissioner for several reasons, and such removal is not subject to review. These reasons are:

1. malfeasance in office, or

2. failure to regularly attend meetings, or

3. any cause that renders the member incapable or unfit to discharge the duties of his office.

OTHER RELATED STATUTORY SECTIONS

There is another section of the workers' compensation statute that is affected by the MCAC and accreditation, but is not under review. It is the "Utilization Review Process" statutory section, §8-43-501, *et. seq.*, C.R.S.. This section discusses and governs the legislative intent that insurers and self-insured employers are required to pay for all reasonable and necessary medical treatment under workers' compensation. However, it recognizes that such insurers should not be required to pay for medical treatment that is not reasonable or necessary. The utilization review process provides a mechanism to review services rendered which may not be reasonably necessary or reasonably appropriate according to accepted professional standards.

Section 8-43-502, C.R.S. governs independent medical examinations and examiners. Among other requirements, IMEs must be Level II accredited. They are recruited from the Level II list of physicians, and must comply with the medical impairment rating guidelines implemented by the Division. An IME may become part of the Division IME panel. Members of this panel perform independent medical examinations at the request of the Director of the Division, or an administrative law judge. Another section of the statute allows the parties to the claim to request an independent medical examination.

One way to determine whether the impairment ratings are effective is to do a more in-depth review of the independent medical examination process and program. Furthermore, an issue critical to IMEs, as it relates to the accreditation program, is whether there is an adequate supply of IMEs to service the workers' compensation system.

Level I and Level II Accreditation

There are two ways by which physicians may become accredited. Level I accreditation is conducted strictly through a home-study course. The participants are tested at one of the testing centers located throughout the state. Level II accreditation may be conducted by either attending a seminar or by home-study. Physicians who have studied at home may take the Level II exam by making an appointment at the Division's office in either Denver or Grand Junction. Level II accreditation seminars are given every 6 months. The current registration fee for Level I accreditation is $150.00. The current registration fee for Level II accreditation is $375.00.

Level II accreditation gives some physicians the option for full or limited accreditation. A physician who passes the entire accreditation exam is fully accredited and may render impairment ratings on any injury. Some physicians must seek full accreditation, such as those in Family Practice, Internal Medicine, Physical Medicine and Rehabilitation, General Practice, Occupational Medicine/Physiatry, General Surgery, and General Osteopathic. Physicians in other specialties are also allowed to seek full accreditation if they desire.

To be fully accredited, physicians must successfully complete an examination in the following impairment sections: Neurology; Pulmonary/Cardiovascular; Upper Extremity and Spine/Lower Extremity; Skin Diseases; Vision; Ear, Nose, Throat, Gastrointestinal; and Mental Disorders. Physicians receiving limited accreditation may do impairment ratings only on those sections listed on their accreditation certificates. Approximately twenty medical specialties are represented in Level II accredited physicians.

The primary objectives of the Level II accreditation program are (1) to standardize the impairment rating process; and (2) to educate physicians as to the rules and regulations mandated by the Division. Included in the materials sent to physicians who have registered for Level II accreditation, is a pre-test that physicians are requested to complete before attending the course. At the conclusion of the accreditation course, the physicians must pass a test. The scores of the pre-course test and the post-test course are compared in order to assess the impact of the instruction.

Approximately 788 providers became Level I accredited the first year. The majority of those accredited were chiropractors - 594. The remaining accredited providers were 185 medical doctors or osteopaths, and 9 podiatrists. The first Level I re-accreditation took place in 1994. The total number that were re-accredited in 1994 was 540 - 71% of the original number. The breakdown according to type of provider is

- 459 chiropractors - 80% of the original number accredited;
- 73 medical doctors and osteopaths - 40% of the original number accredited (most of those who did not seek level I re-accreditation were already level II accredited);
- 8 podiatrists - 89% of the original number accredited.

Currently, there are 718 providers who are Level I accredited. Approximately 410 providers, or 31% of Level I and Level II accredited providers also participate in the Division Utilization Review Program as candidates for the new treating provider selection process.

Physicians did not have to become Level II accredited until January 1, 1993. Currently, there are 599 Level II accredited physicians. Because accreditation is valid for 3 years, the Level II accredited physicians who were first accredited must become re-accredited in 1995. The total number of physicians to be re-accredited in 1995 is 323. In 1996, 158 physicians will need to be re-accredited.

From December of 1994 until May of 1995, the Division sent 196 registration packets to providers interested in becoming Level I and II accredited for the first time. The Division is noticing a trend that many doctors are becoming accredited because their employers require it. Also, some insurance companies, on their applications for a doctor to join their list as a treating physician, ask them whether they are state accredited.

As of this writing, the Division has scheduled 4 **re-accreditation** seminars in 1995. Two will be in Denver, one will be in Grand Junction, and one will be in Colorado Springs. The seminars will teach the essentials of the new medical treatment guidelines, as well as review administrative issues and range of motion and impairment ratings.

Because any physician who does medical impairment ratings must be Level II accredited, and independent medical examiners do medical impairment ratings, all IMEs must be level II accredited. The Division recruits IMEs from the Level II accreditation list. Approximately 261 physicians, or 44% are members of the Division IME panel.

When providers become accredited, they sign a compliance agreement with the Division that states that they will adhere to medical treatment guidelines, utilization standards and rules, and all workers' compensation laws and rules.

If there is a dispute as to an impairment rating, the parties involved may try to agree upon a physician for the claimant to see in order to obtain an independent medical examination and impairment rating. If the parties cannot agree upon a physician, the Division selects an IME. The IME's opinion may be overruled only by a court of law by a showing of clear and convincing evidence. The IME section of the statute is not under review, although it affects, and is affected by the accreditation program.

Since its inception, Colorado's accreditation program has become a model for the nation. Florida has implemented a curriculum based on the Division's accreditation program, as has a private national program. Furthermore, 11 other states, plus the U.S. Department of Labor, have contacted the Division requesting information about Colorado's accreditation program.

Medical Care Accreditation Commission

The legislature created the MCAC to advise the Division about

1. fee schedules for all medical, surgical, hospital, dental, nursing, and vocational rehabilitation treatment,
2. medical impairment rating guidelines,
3. medical treatment guidelines,
4. utilization standards, and
5. denial of surgery standards and their relationship to maximum medical improvement.

These are traditional issues with which medical cost containment strategies have been concerned. They are also the traditional areas where there is disagreement between the different constituents in the workers' compensation system. To gather information so that it may make informed recommendations for rulemaking, the MCAC has established task forces for the areas in which they must advise the Division. The following subjects have been studied in task forces and recommendations have been made to the Division:

1. Independent Medical Examination Program,

2. Utilization Review Program,

3. Case Management/Managed Care,

4. Functional Capacity Evaluations,

5. Hospital, Medical, Dental, and Physical Medicine Fees,
   the statute requires an annual review

6. Apportionment,

7. Permanent Impairment Rating Guidelines;
   the statute requires an annual review

8. Medical Treatment Guidelines.

   ◊ Low back pain guidelines were implemented in April 1993. Upper extremity, and lower extremity were implemented in 1994. These three types of injuries make up 70% of the injuries treated under workers' compensation. Cumulative trauma, reflex sympathetic dystrophy, and shoulder injury are being developed. The statute requires an annual review.

The MCAC must approve all members of the task force. They send out recruitment letters and receive resumes from potential members. Some have criticized the make-up of the task forces as being controlled by the medical community, although the MCAC diligently tries to ensure that all constituencies are represented. Additionally, the MCAC monitors the progress of task forces to ensure that they are doing their job and that one group's agenda is not forced through as a recommendation. Also, those task force members who have held a minority opinion are free to express their opinions and concerns to the Division and they have done so.

Medical Care Accreditation Commission

Fair, efficient, and competent medical care is an essential component of a well functioning workers' compensation program. But within the workers' compensation system, medical care delivery has been and continues to be controversial and adversarial. The issues facing the legislature in 1991 are the same issues the workers' compensation community continues to wrestle with today - for example, medical cost containment, adequate medical care, and affordable insurance premiums.

Through SB 91-218, the legislature has charged the MCAC with the important goal of revising essential components of the workers' compensation system. Essentially, their recommendations affect the medical cost containment process and procedures of the Division. With 45% of the workers' compensation dollar going to medical treatment, controlling its cost is an important responsibility. Even though the MCAC has no power to promulgate rules as an advisory board, the Division relies on its recommendations when making decisions.

Constituents have input into rulemaking

The key to the success of the MCAC lies in the balance of the make up of its members. This commission brings all of the parties affected by workers' compensation together to resolve some of the issues facing the system. Because all parties are included in the process, most of the disagreements on issues are debated before the Division promulgates a rule. Additionally, inclusion generates greater faith in the process and product. The constituencies know that everyone's concerns have been heard. If only physicians had input into, e.g., practice guidelines, other providers and groups might be suspicious that the work product is self-serving.

There has been some criticism of the MCAC's recommendations. This criticism focuses on the fact that the MCAC proposals are a result of consensus and compromise between medical and non-medical interests, and not on scientific principles. This criticism ignores the reality that workers' compensation is not a system based solely on scientific principles. It is a program that combines medicine, insurance, risk management, business, and law. As parties in the system, all constituencies should have input into the creation of rules that affect them. The legislature has asked the MCAC to hammer out solutions to issues that had previously been left to the political process.

Even without the MCAC, the workers' compensation statute still requires the Division to create fee schedules, impairment rating guidelines, treatment guidelines, and utilization standards. Essentially, the MCAC and its task forces are volunteer consultant groups. Through the MCAC, the Division is able to get input from the affected communities, provide a way for constituent representatives to address particular concerns, and utilize the expertise of its members. If the Division had to pay these members of the MCAC and its task forces, as consultants, it could not afford to do so.

The statute required that the Division promulgate rules by January 1, 1992, "establishing a system for the determination of medical treatment guidelines and utilization standards and medical impairment rating guidelines for impairment ratings as a percent of the whole person or affected body part based on the revised third edition of the '*American Medical Association Guides to the Evaluation of Permanent Impairment*'."

It is not clear what "establishing a system for the determination . . ." means. If it means to have such guidelines in place through the rulemaking process, then this deadline was not met. In fact, some medical treatment guidelines are still being created today. However, if it means to have the MCAC in place and functioning, then the deadline was met. Six months is too short of a time in which to implement practice guidelines and utilization standards; therefore, it is reasonable to assume that the legislature intended the MCAC to be in place and working by January 1992.

The experience of the MCAC has shown that it takes about 1 year for guideline recommendations to become a rule. The new guidelines and standards must then be disseminated to the medical community for use. Apparently, no one anticipated the amount of time and resources needed to implement the statutory mandates. Neither did anyone anticipate the need to provide classes to educate providers about the new guidelines and rules.

Level I and Level II Accreditation

As previously stated, the Level I accreditation program was set up to instruct medical providers about current medical guidelines, and the administrative and legal aspects of workers' compensation. Level II accreditation was set up to instruct physicians on how to do impairment ratings, and educate them about current medical guidelines, and the administrative and legal aspects of workers' compensation.

At the time that SB 91-218 was passed, there was no educational program that taught medical providers the particulars of Colorado's workers' compensation system. Providers had to learn the system by trial and error. Ignorance on the part of providers about the administrative and legal aspects of the system causes delays in administering cases, and causes unnecessary complications in dispensing medical care to injured workers.

The legislature hoped to rectify these administrative problems, by offering an accreditation program that explained the workers' compensation system to medical providers. The result was the Level I accreditation curriculum. Level I accreditation also addressed the perceived problem of overutilization of treatment by chiropractors.

Removes litigious elements

The new workers' compensation legislation changed the way benefits are calculated for workers who are permanently partially injured. The legislature hoped to lower the cost of disability/impairment benefits by removing as many litigious elements of the process as possible. Therefore, the medical impairment rating, and hence the physician doing the rating, became a major component in determining compensation. To ensure that physicians were competent to perform impairment ratings, SB 91-218 included mandatory Level II accreditation which taught physicians how to do them. The goal was for fair and consistent impairment ratings, thus, reducing the number of disputes over those ratings.

One concern about imposing accreditation on medical providers was that such an imposition would decrease the number of participants in the workers' compensation system. If that happened, the cost of the medical care might increase while the quality of care might decrease. These concerns apparently have not manifested. Employers and insurance companies are pressuring providers to become accredited. Additionally, physicians want to provide a continuity of service to their patients; therefore, they have an incentive to become Level II accredited.

One criticism of the accreditation program has been that there have been no revocations of accreditation. The Division has been criticized for not enforcing the rules regarding noncompliant doctors. There is no independent peer review process to ensure that providers are complying with the law. The Division has looked into hiring a private company to do a complete peer review of all of the providers in the system and found that it would cost approximately $100,000. At this time, the cost is prohibitive. The Division is still exploring different methods for a more comprehensive way to review the performance of accredited medical providers.

The only way the Division finds out about potential problems is when a complaint is filed. For example, an insurance company may file a complaint about an IME because the IME has not filed a timely report. Because an IME must be Level II accredited, the IME section notifies the Accreditation Director that there is a complaint. If the problem with the IME is administrative in nature, the director of the accreditation program contacts the provider and reminds the provider that the Division has the authority to revoke accreditation.

If the complaint is a medical issue, such as an impairment rating that does not follow the correct guidelines, the medical director contacts the physician to determine if the violation is due to a simple mistake or deliberate wrongdoing. In most cases, this kind of contact is all that is necessary to rectify the problem. There have been a few instances where providers have removed themselves voluntarily from the accreditation lists because the Division was going to institute revocation proceedings.

The medical director, a part-time position within the Division, has the responsibility to advise the Division on peer review for the accreditation program. As this program expands, the medical director will not be able to handle peer review alone. Therefore, it is necessary for the Division to create another enforcement procedure.

Before the Division may revoke a provider's accreditation, a hearing must be held. As a result of the hearing, the ALJ makes a recommendation to the Division about whether revocation is appropriate.

Are the MCAC and Accreditation Programs effective?

When the accreditation programs were implemented, no objective method for measuring their effectiveness was established. The only measurements the Division has are anecdotal, such as the pre-seminar test score versus the post-seminar test score, and the program evaluations filled out by the participants. According to a program evaluation conducted by the Division in 1993, the scores on the objective portion of the test increased about 20% points after Level II training. The impairment rating scores improved about 35% points after physicians completed the training.

Perhaps a more objective measurement is the fact that since June of 1992, 4,440 Division IMEs have been requested, and of that number, there have been only 50 hearings over disputed IME **findings.** In this context, an IME finding is different from a medical impairment rating because a finding might also include a dispute about maximum medical improvement. The ALJ decisions have resulted in the following:

56%	28 ALJ decisions upheld the IME findings
30%	15 ALJ decisions overturned the IME findings
8%	4 ALJ decisions were split on the IME findings
6%	3 ALJ decisions dealt with other issues
100%	50

Between October 1993 and April 1995, the Accreditation Coordinator has received 122 complaints about Level II accredited physicians. The breakdown of the complaints are the following:

Dispute over the impairment rating	- 51 complaints	41.8%
Range-of-motion	- 26 complaints	21.3%
Missing forms	- 16 complaints	13.1%
Late reporting	- 8 complaints	6.5%
Miscellaneous	- 21 complaints	17.2%

These complaints involve 101 physicians, or 16.8% of all Level II accredited physicians. There is no direct comparison possible between pre SB 91-218 and post SB 91-218 because there was no accreditation program prior to SB 91-218. However, this is a low number of complaints. No physician accreditation has been revoked yet because there has not been time for revocation criteria to have been implemented. However, this situation is changing. The Division has developed criteria for the accreditation revocation process and procedures to do so are being finalized.

Colorado was the first state to institute an accreditation program so the Division did not have any other state's experience on which to draw when designing its programs. Also, the type of statistical information needed to determine the effectiveness of accreditation is not the kind of which the Division's computer software keeps track. For example, the Division does not keep track of the impairment ratings given by each physician. Therefore, without going through each case file by hand, there is no way to determine whether impairment ratings are becoming more consistent.

The Division recognizes that objective outcome measurements are necessary to measure both the work of the MCAC and the accreditation programs. Currently, the Division is trying to get grant money to set up a method that will measure the effectiveness of accreditation. Also, the medical director is developing an evaluation program to determine if there has been an improvement in the quality and delivery of medical care since the implementation of guidelines and standards.

The reforms that SB 91-218 brought to Colorado's workers' compensation system apparently had an immediate impact on premium rates. In 1991, NCCI dropped its request for the 38% rate increase. The workers' compensation rates remained the same during 1992 and 1993. In 1994, NCCI recommended a 5% rate decrease. However, there is no way to determine whether the MCAC and the accreditation programs had causal relationship to these decreases.

There is anecdotal evidence that the programs are supported by those physicians who do workers' compensation cases. The Colorado Medical Society has not had any complaints from its constituents about it. The program evaluations of both the Division and the University of Colorado Medical School (who gives continuing education credit for the programs) also indicate approval for the programs. And medical care delivery systems are requiring their providers become accredited.

RECOMMENDATIONS

Should the Medical Care Accreditation Commission be Continued?

This review concludes that this commission should be continued with the next Sunset date to be in approximately three years. The legislature directed the MCAC to advise the Division about critical medical cost containment issues. Should the MCAC be disbanded, the Division is still required to create, implement, and update these cost containment guidelines. The MCAC is an invaluable resource to the division because of the expertise and experience of its members. It also provides all of the interested constituencies in the workers' compensation system a method with which to express their particular concerns.

The MCAC has not finished the job it was given by the legislature. There are guidelines, fee schedules, and standards that must still be implemented. A reasonable estimate of when guidelines and standards should be in place is three years. Once these guidelines and standards are in place and operating in the medical community, the necessity of the MCAC in its present form may be measured more effectively.

Recommendation 1 - The General Assembly should continue the Medical Care Accreditation Commission.

Should the Medical Provider Accreditation Program be Continued?

This review concludes that the Level I and Level II accreditation programs should be continued. The goal of the program is to improve the efficiency of delivering medical care by (1) enhancing providers' knowledge of the workers' compensation system, and (2) teaching medical impairment ratings to physicians so that such ratings are accurate, fair, and consistent.

As stated in the Sunset Analysis of this report, there was a fear that the accreditation program might decrease the number of providers in the system, thereby increasing medical cost and lowering the standard of care. There is no evidence that this has happened. Currently, there are 718 Level I accredited providers and 599 Level II accredited physicians, and more providers are registering for the program. Evaluations by the Division and by the University of Colorado Medical Continuing Education program indicate that the program successfully enhances providers' knowledge of the workers' compensation system.

Recommendation 2 - The Level I and II Accreditation Programs should be continued.

The Workers' Compensation Division Should Have the Authority to Decide, by Rule, Which Impairment Guide to Use

Sections 8-42-101(3.5)(a)(II) and (3.7), C.R.S. state that medical impairment ratings must be based on the *American Medical Association Guides to the Evaluation of Permanent Impairment (3rd ed. revised)*. This requirement is too restrictive for the MCAC, the accreditation program, the Division, and for the workers' compensation community.

The *AMA Guides (3rd ed. revised)* is no longer in print. Colorado is one of only six states, plus Ontario, Canada, that uses the *AMA Guides (3rd ed. revised)*. There is already a fourth edition in print. The Division had to enter into a private contractual relationship with the publisher of the *AMA Guides* to print 500 of them for use. The Division disseminates these guides to Level II accredited physicians, but it is practically impossible for other constituents to obtain copies of it.

Furthermore, there is no assurance that the publisher will continue to print a special order for Colorado. This statutory requirement places Colorado in the precarious position of basing an important part of its workers' compensation law on a guide which, in the future, one may not be able to acquire, and which is currently outdated.

The alternative - using the current edition of the *AMA Guides*, without giving the Division the authority to accept, reject, or modify those guides - is not acceptable. There may be guidelines in a current edition that would complicate the rating system, or cause inconsistencies in impairment ratings. For example, the fourth edition of the guides gives the rating physician a choice of methods on how to do some impairment ratings. Giving physicians such choices would not fit in with the objective of standardizing impairment ratings.

Therefore, the Division should have the authority to decide, by rule, which impairment rating guide should be used as a basis to establish medical impairment ratings. Additionally, the Division should have the authority to change, reject, or fill in the blanks of the impairment rating guide.

Recommendation 3 - The General Assembly should amend the statute so that the Division of Worker's Compensation had the authority to decide, by rule, which medical impairment rating guide to use for medical impairment ratings.

Expand the Scope of the Next Sunset Review

As stated earlier in this report, there are other sections of the workers' compensation statute that are closely linked to the accreditation program and the MCAC. If the legislature desires a more complete accounting of the consequences of SB 91-218, the scope of the next Sunset Review should be expanded to include those parts of the statute that are essential to medical cost containment.

Recommendation 4 - The General Assembly should expand the scope of the next sunset review.

APPENDICES

Sunset Statutory Evaluation Criteria

(I) Whether regulation by the agency is necessary to protect the public health, safety and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen which would warrant more, less or the same degree of regulation;

(II) If regulation is necessary, whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest, considering other available regulatory mechanisms and whether agency rules enhance the public interest and are within the scope of legislative intent;

(III) Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures and practices of the Department of Regulatory Agencies and any other circumstances, including budgetary, resource and personnel matters;

(IV) Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively;

(V) Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates;

(VI) The economic impact of regulation and, if national economic information is available, whether the agency stimulates or restricts competition;

(VII) Whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession;

(VIII) Whether the scope of practice of the regulated occupation contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action;

(IX) Whether administrative and statutory changes are necessary to improve agency operations to enhance public interest.

Worker's Compensation Medical Care Accreditation Commission and Accreditation of Health Care Providers Statute

8-42-101. Employer must furnish medical aid - approval of plan - fee schedule - contracting for treatment - no recovery from employee - medical treatment guidelines - accreditation of physicians - repeal. (1) (a) Every employer, regardless of said employer's method of insurance, shall furnish such medical, surgical, dental, nursing, and hospital treatment, medical, hospital, and surgical supplies, crutches, and apparatus as may reasonably be needed at the time of the injury or occupational disease and thereafter during the disability to cure and relieve the employee from the effects of the injury.

(b) In all cases where the injury results in the loss of a member or part of the employee's body, loss of teeth, loss of vision or hearing, or damage to an existing prosthetic device, the employer shall furnish within the limits of the medical benefits provided in paragraph (a) of this subsection (1) one artificial member, glasses, a hearing aid, a brace, and any other external prosthetic device, including dentures, which are reasonably required to replace or improve the function of each member or part of the body or prosthetic device so affected or to improve the employee's vision or hearing. The employee may petition the division for a replacement of any artificial member, glasses, hearing aid, brace, or other external prosthetic device, including dentures, upon grounds that the employee has undergone an anatomical change since the previous device was furnished, and that the anatomical change is directly related to and caused by the injury, and that the replacement is necessary to improve the function of each member or part of the body so affected or to relieve pain and discomfort. Implants or devices necessary to regulate the operation of, or to replace, with implantable devices, internal organs or structures of the body may be replaced when the authorized treating physician deems it necessary. Every employer subject to the terms and provisions of articles 40 to 47 of this title must insure against liability for the medical, surgical, and hospital expenses provided for in this article, unless permission is given by the director to such employer to operate under a medical plan, as set forth in subsection (2) of this section.

(2) Every such plan, which is agreed to between the employer and employee, for the furnishing of medical, surgical, and hospital treatment, whether or not the employee is to pay any part of the expense of such treatment, before being put into effect, shall receive the approval of the director. The director has full power to formulate the terms and conditions under which any such plan may operate and the essentials thereof, and at any time the director may order modifications or changes in any such plan or withdraw prior approval thereof. No plan shall be approved by the director which relieves the employer from the burden of assuming and paying for any part of the medical, surgical, and hospital services and supplies required.

(3) (a) (I) The director, upon the advice of the commission, shall establish a schedule fixing the fees for which all medical, surgical, hospital, dental, nursing, and vocational rehabilitation treatment rendered to employees under this section shall be compensated, and it is unlawful, void, and unenforceable as a debt for any physician, chiropractor, hospital, person, or institution to contract with, bill, or charge any patient for services, rendered in connection with injuries coming within the purview of this article or an applicable fee schedule, which are or may be in excess of said fee schedule unless such charges are approved by the director. Fee schedules shall be reviewed on or before July 1 of each year by the director, and appropriate health care practitioners shall be given a reasonable opportunity to be heard as required pursuant to section 24-4-103, C.R.S., prior to fixing the fees, impairment rating guidelines which shall be based on the revised third edition of the "American Medical Association Guides to the Evaluation of Permanent Impairment", in effect as of July 1, 1991, and medical treatment guidelines and utilization standards. The director shall promulgate rules and regulations concerning reporting requirements, penalties for failure to report correctly or in a timely manner, utilization control requirements for services provided under this section, and the accreditation process in subsection (3.6) of this section.

(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (a) the fees set forth in the schedule established pursuant to subparagraph (I) of this paragraph (a) shall be those fees in effect immediately prior to July 1, 1991, and such fees shall remain in effect until July 1, 1995.

(III) Notwithstanding the provisions of subparagraph (I) of this paragraph (a), until the impairment rating guidelines and medical treatment guidelines and utilization standards required by subparagraph (I) of this paragraph (a) and subsection (3.5) of this section are adopted and level I accreditation is received, compensation for fees for chiropractic treatments shall not be made more than ninety days after the first of such treatments nor after the twelfth such treatment, whichever first occurs, unless the chiropractor has received level I accreditation.

(b) Medical treatment guidelines and utilization standards, developed by the director, with input from the commission, shall be used by health care practitioners for compliance with this section.

(3.5) (a) (I) "Physician" means, for the purposes of the level I and level II accreditation programs, a physician licensed under the "Colorado Medical Practice Act". For the purposes of level I accreditation only and not level II accreditation, "physician" means a dentist licensed under the "Dental Practice Law of Colorado", a podiatrist licensed under the provisions of article 32 of title 12, C.R.S., and a chiropractor licensed under the provisions of article 33 of title 12, C.R.S. No physician shall be deemed to be accredited under either level I or level II solely by reason of being licensed.

(II) The director shall promulgate rules by January 1, 1992, establishing a system for the determination of medical treatment guidelines and utilization standards and medical impairment rating guidelines for impairment ratings as a percent of the whole person or affected body part based on the revised third

edition of the "American Medical Association Guides to the Evaluation of Permanent Impairment", in effect as of July 1, 1991.

(b) A medical impairment rating system shall be made available by the director by January 1, 1992.

(c) There is hereby created in the division the workers' compensation medical care accreditation commission to advise the director on the fee schedule established pursuant to subparagraph (I) of paragraph (a) of subsection (3) of this section and on medical impairment rating guidelines and medical treatment guidelines and utilization standards, as well as the denial of surgery and its relationship to maximum medical improvement. Such advisory commission shall consist of seven citizens of this state who shall be appointed by the governor with the consent of the senate. The governor shall consider any recommendations of the director and may receive input from appropriate professional societies.

(d) Two members of the commission shall be physicians licensed to practice medicine in this state, one member shall be a chiropractor licensed to practice in this state, two members shall be consumers, one of whom shall represent the interests of small business and one of whom shall represent the interests of risk management, one member shall be a representative of workers injured on the job, and one member shall be a representative of the insurance industry. In addition, the medical director serving pursuant to paragraph (n) of subsection (3.6) of this section shall serve as an ex-officio member of the commission.

(e) All members of the commission shall serve terms of three years; except that the terms of the members initially appointed by the governor shall be as follows:

(I) Two members, one of whom is a licensed physician and the other of whom is a consumer representing either the interests of small business or the interests of risk management, shall be appointed for terms ending July 1, 1992;

(II) Two members, one of whom is a licensed physician and one of whom is a consumer representing either the interests of small business or risk management, shall be appointed for terms ending July 1, 1993; and

(III) Three members, one of whom is a representative of the insurance industry, one of whom is a licensed chiropractor, and one of whom is a representative of workers who have been injured on the job, shall be appointed for terms ending July 1, 1994.

(f) All initial appointments shall be made by the governor as soon as practicable but in no event later than July 1, 1991.

(g) The chair of the commission shall be elected by its members every two years.

(h) The physicians who are members of the commission shall have either a minimum of three years' experience in occupational medicine, with thirty percent of their practice devoted to cases involving occupational injuries, or a minimum of five years' experience in occupational medicine, with fifteen percent of their practice devoted to cases involving occupational medicine. The balance of the practice of such members shall reflect a diversity of areas of practice, including family and internal medicine.

(i) Members of the commission who are not employees of the state shall receive fifty dollars per diem for attendance at official meetings and shall be reimbursed for reasonable and necessary travel expenses incurred in the conduct of commission business. Travel expenses shall be reimbursed at the rate authorized for state employees.

(j) The governor shall remove any member of the commission for malfeasance in office, failure to regularly attend meetings, or any cause that renders such member incapable or unfit to discharge the duties of his office, and any such removal shall not be subject to review.

(k) (I) This subsection (3.5) is repealed, effective July 1, 1996.

(II) Prior to such repeal the commission and the accreditation process created by this subsection (3.5) and subsection (3.6) of this section shall be reviewed as provided for in section 24-34-104, C.R.S.

(3.6) The director, with input from the commission, shall establish a two-tier accreditation system which shall be comprised of the following programs:

(a) (I) A program which establishes the accreditation requirements for physicians providing primary care to patients who have, as a result of their injury, been unable to return to work for more than three working days, referred to in this section as "time-loss injuries", which program shall be voluntary except in the case of chiropractors, for whom it shall be mandatory, and which shall be known as level I accreditation; and

(II) A program which establishes the accreditation requirements for physicians providing impairment evaluation of injured workers, which program shall be known as level II accreditation.

(b) On and after January 1, 1993, a physician who provides impairment evaluation of injured workers shall complete and must have received accreditation under the level II accreditation program. Specialists who do not render primary care to injured workers and who do not perform impairment evaluations do not require accreditation. The facility where a physician provides such services cannot be accredited.

(c) Both the level I and level II accreditation programs shall be implemented and available to physicians no later than July 1, 1992. All physicians who are required to be accredited shall complete the level II accreditation program or programs no later than July 1, 1993.

(d) The level I and level II accreditation programs shall operate in such a manner that the costs thereof shall be fully met by registration fees paid by the physicians. The registration fee for level I accreditation shall not exceed two hundred fifty dollars, and the registration fee for level II accreditation shall not exceed four hundred dollars. The registration fee for each program shall cover the cost of all accreditation course work and materials.

(e) The accreditation system shall be established so as to provide physicians with an understanding of the administrative, legal, and medical roles and in such a manner that accreditation is accessible to every licensed physician, with consideration of specialty and geographic diversity.

(f) Initial accreditation shall be for a three-year period and may be renewed for successive three-year periods. The director by regulation may determine any additional training program required prior to accreditation renewal.

(g) The director shall, upon good cause shown, revoke the accreditation of any physician who violates the provisions of this subsection (3.6) or any rule or regulation promulgated by the director pursuant to this subsection (3.6), following a hearing on the merits before an administrative law judge, subject to review by the industrial claim appeals office and the court of appeals by petition for writ of certiorari, in accordance with all applicable provisions of article 43 of this title.

(h) If a physician whose accreditation has been revoked submits a claim for payment for services rendered subsequent to such revocation, the physician shall be considered in violation of section 10-1-127, C.R.S., and neither an insurance carrier or self-insured employer shall be under any obligation to pay such claim.

(i) A physician who provides treatment for nontime loss injuries need not be accredited to be reimbursed for the costs of such treatment pursuant to the provisions of the "Workers' Compensation Act of Colorado".

(j) The division shall be charged with the responsibility of providing sufficient staff, facilities, and administrative support to accomplish the tasks of the commission.

(k) The division shall make available to insurers a list of all accredited physicians and a list of all physicians whose accreditation has been revoked. Such lists shall be updated on a monthly basis.

(l) The registration fees collected pursuant to paragraph (d) of this subsection (3.6) shall be transmitted to the state treasurer, who shall credit the same to the physicians accreditation program cash fund, which is hereby created in the state treasury. Moneys in the physicians accreditation program cash fund are hereby continuously appropriated for the payment of the direct costs of providing the level I and level II accreditation courses and materials.

(m) All administrative costs associated with the level I and level II accreditation programs and all costs associated with the duties and responsibilities of the commission, including reimbursement of travel expenses as authorized under paragraph (i) of subsection (3.5) of this section, shall be paid out of the workers' compensation cash fund in accordance with appropriations made pursuant to section 8-44-112 (7).

(n) The director shall contract with the medical school of the University of Colorado for the services of a medical director to advise the director and to work with the commission on issues of accreditation, impairment rating guidelines, medical treatment guidelines and utilization standards, and case management and to consult with the director on peer review activities as specified in this subsection (3.6) and section 8-43-501. Such medical director shall be a medical doctor licensed to practice in this state with experience in occupational medicine. The director may contract with an appropriate private organization which meets the definition of a utilization and quality control peer review organization as set forth in 42 U.S.C. sec. 1320c-1 (1) (A) or (1) (B), to conduct peer review activities under this subsection (3.6) and section 8-43-501 and to recommend whether or not adverse action is warranted.

(o) Except as provided in this subsection (3.6), on and after July 1, 1993, neither an insurance carrier nor a self-insured employer or injured worker shall be liable for costs incurred for services rendered by a physician in the impairment evaluation of a patient if such attending physician is not accredited at a level II accreditation pursuant to the provisions of this subsection (3.6).

(p) (I) For purposes of this paragraph (p):

(A) "Case management" means a system developed by the insurance carrier in which the carrier shall assign a person knowledgeable in workers' compensation health care to communicate with the employer, employee, and treating physician to assure that appropriate and timely medical care is being provided.

(B) "Managed care" means the provision of medical services through a recognized organization authorized under the provisions of parts 1, 3, and 4 of article 16 of title 10, C.R.S., or a network of medical providers accredited to practice workers' compensation under this subsection (3.6).

(II) On or before July 1, 1993, every employer or its insurance carrier shall offer at least managed care or medical case management in the counties of Denver, Adams, Jefferson, Arapahoe, Douglas, Boulder, Larimer, Weld, El Paso, Pueblo, and Mesa and shall offer medical case management in all other counties of the state.

(q) The division is authorized to accept moneys from any governmental unit as well as grants, gifts, and donations from individuals, private organizations, and foundations; except that no grant, gift, or donation may be accepted by the division if it is subject to conditions which are inconsistent with this article or any other laws of this state or which require expenditures from the workers' compensation cash fund which have not been approved by the general assembly. All moneys accepted by the division shall be transmitted to the state treasurer for credit to the workers' compensation cash fund.

(r) (I) This subsection (3.6) is repealed, effective July 1, 1996.

(II) Prior to such repeal the commission and the accreditation process created by subsection (3.5) of this section and this subsection (3.6) shall be reviewed as provided for in section 24-34-104, C.R.S.

(3.7) On and after July 1, 1991, all physical impairment ratings used under articles 40 to 47 of this title shall be based on the revised third edition of the "American Medical Association Guides to the Evaluation of Permanent Impairment", in effect as of July 1, 1991. For purposes of determining levels of medical impairment pursuant to articles 40 to 47 of this title 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.

(4) Once there has been an admission of liability or the entry of a final order finding that an employer or insurance carrier is liable for the payment of an employee's medical costs or fees, a medical provider shall under no circumstances seek to recover such costs or fees from the employee.

(2) Many of the cases annotated below which arose prior to July 1, 1987, were decided under the former provisions of 8-49-101 which have been substantially amended or which have been repealed.