COLORADO DEPARTMENT OF REGULATORY AGENCIES
OFFICE OF POLICY AND RESEARCH

PHYSICIAN ACCREDITATION UNDER THE WORKERS' COMPENSATION ACT OF COLORADO

2002 SUNSET REVIEW

STATE OF COLORADO

DEPARTMENT OF REGULATORY AGENCIES
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Bill Owens
Governor

October 15, 2002

Members of the Colorado General Assembly
c/o the Office of Legislative Legal Services
State Capitol Building
Denver, Colorado 80203

Dear Members of the General Assembly:

The Colorado Department of Regulatory Agencies has completed the evaluation of the physician accreditation program under the Workers' Compensation Act of Colorado. I am pleased to submit this written report, which will be the basis for my office's oral testimony before the 2003 committee of reference. The report is submitted pursuant to section 24-34-104(8)(a), of the Colorado Revised Statutes (C.R.S.), 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 supporting materials to the office of legislative legal services no later than October 15 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 sections 101(3.5) and (3.6) of Article 42 of Title 8, C.R.S. The report also discusses the effectiveness of the Department of Labor and Employment, Division of Workers' Compensation and its staff in carrying out the intent of the statutes, and makes recommendations for statutory changes in the event this regulatory program is continued by the General Assembly.

Sincerely,

M. Michael Cooke

M. Michael Cooke
Executive Director

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Background

The Sunset Process

Certain regulatory functions of the Department of Labor and Employment, Division of Workers' Compensation (Division), in accordance with Sections 101(3.5) and (3.6), Article 42 of Title 8, of the Colorado Revised Statutes (C.R.S.), shall terminate on July 1, 2003, unless continued by the General Assembly. During the year prior to this date, it is the duty of the Department of Regulatory Agencies (DORA) to conduct an analysis and evaluation of those functions pursuant to section 24-34-104 (9)(b), C.R.S.

The purpose of this review is to determine whether the physician accreditation program under the Workers' Compensation Act of Colorado (Act) should be continued for the protection of the public and to evaluate the performance of the Division and its staff. During this review, the Division must demonstrate that there is still a need for the physician accreditation program and that the regulation is the least restrictive regulation consistent with the public interest. DORA's findings and recommendations are submitted via this report to the legislative committee of reference of the Colorado General Assembly. Statutory criteria used in sunset reviews may be found in Appendix A on page 26.

Methodology

As part of this review, DORA staff attended a Workers' Compensation Medical Advisory Committee (Committee) meeting, interviewed Division staff, reviewed Committee records and minutes, interviewed officials with state and national professional associations, interviewed health care providers and consumer advocates and reviewed Colorado statutes and Division rules.

Profile of the Profession

The physician accreditation program (Program) does not regulate a profession. Rather, it represents a comprehensive approach to the provision of workers' compensation medical services by educating physicians as to the intricacies of providing care in the workers' compensation system, as well as the methodology used to conduct impairment ratings in that system.

Two levels of accreditation are available. Level I Accreditation simply ensures that the practitioner knows and understands how the workers' compensation system works, as well as the documentation requirements for providing treatment and obtaining reimbursement.

Level I Accreditation is strictly voluntary for medical doctors, osteopaths, dentists and podiatrists who provide primary care to workers' compensation claimants. These practitioners may treat workers' compensation claimants without first obtaining Level I Accreditation, although they are still required to adhere to the rules of the workers' compensation system. However, Level I Accreditation is mandatory for any chiropractor who provides primary care to workers' compensation claimants with time-loss injuries.

Level II Accreditation is available only to licensed medical doctors and osteopaths. Only a physician who obtains Level II Accreditation may conduct impairment evaluations on workers' compensation claimants. An impairment evaluation renders an impairment rating, which is a scientifically deduced number. The impairment rating is a major factor in determining the benefits to which the workers' compensation claimant is entitled.

Accreditation assists all of these professionals in navigating the workers' compensation system and better understanding the nature and goal of medical practice under that system. While the general goal of both traditional medicine and medicine under the workers' compensation system is to return the patient to normal activity levels, the strategy utilized to achieve this goal can differ. The general nature of traditional medicine is to initially treat a given illness or injury more conservatively, and become more aggressive as the situation warrants. Medicine under the workers' compensation system, on the other hand, often advocates that an illness or injury initially be treated more aggressively so as to return the employee to work as quickly as possible without sacrificing the quality of medical care. The accreditation program assists physicians in adapting to this change in strategy.

History of Regulation

"Workers' compensation" is a comprehensive term that encompasses those laws that provide compensation for losses resulting from work-related injuries, illnesses or death. Compensation is provided regardless of fault and in accordance with a definite schedule based upon loss or impairment of the worker's wage-earning power.[1]

Workers' compensation statutes were originally enacted to indirectly alleviate the poor working conditions commonly found throughout the U.S. in the early 1900s. These poor conditions caused frequent workplace deaths, injuries and illnesses. To make matters worse, employees often had little legal recourse available to them.

In response to these circumstances, many states began passing workers' compensation statutes in which a "bargain" was struck between employers and employees. Employees were assured of safe working conditions and a reliable system of compensation in the event of injury. In exchange, employees surrendered their common law rights to other legal remedies for injuries sustained. Thus, employers provided a safe workplace and were protected from costly personal injury lawsuits.[2]

In 1915, Colorado became one of the first states to implement legislation relating to workers' compensation. Naturally, it has been amended many times since then, but its overarching principle remains the same: compensation for work-related injuries and illnesses depends upon the employee-employer relationship, not upon demonstrable negligence or fault.

More modern workers' compensation statutes became fairly complicated and caused substantial litigation as many injured employees struggled to collect their benefits. Prior to 1991, the workers' compensation system in Colorado was controversial and adversarial. Claimants, employers and their attorneys appeared before a judge, presented their medical experts and argued their cases. In the end, a judge, not a physician, determined the severity of the workers' injuries and, thus, the

[1] 82 AM JUR. 2d, Workmen's Compensation section 1.
[2] *Scott* A. Carlson, The *ADA and the Illinois Workers' Compensation Act: Can Two "Rights" Make a* Wrong? 19 *S.* ILL. U.L.J. 567, 569 (1995).

benefits to which the worker was entitled. In making this determination, the judge could consider many factors, such as the treating physician's evaluation, the claimant's physical limitations, age, education and previous job experience. Thus, the physician's evaluation was only one factor among many to be considered.

In response to this situation, the General Assembly passed Senate Bill 91-218, which substantially revised the workers' compensation system and created the Division. Included in this comprehensive overhaul was the creation of a system of accreditation for physicians who work with workers' compensation claimants.

Generally, those physicians who seek to treat workers' compensation claimants may, but do not need to, obtain Level I Accreditation. This level of accreditation simply seeks to educate healthcare providers of the bureaucratic and administrative requirements of working in the workers' compensation system and treating such patients.

Level II Accreditation, on the other hand, is required for those physicians who seek to conduct impairment ratings on injured workers. It is important to note that "impairment" is not synonymous with "disability." Impairment is a medical assessment that determines whether and to what degree the functional ability of a certain body part has changed since the illness or injury. A disability is more of a social assessment of the individual's ability to function in society with that impairment.

Under Colorado's workers' compensation system, benefits are awarded to an injured worker based on impairment, which is determined by an impairment rating. Level II Accreditation seeks to ensure that all physicians who perform impairment ratings do so following the same set of procedures to better ensure consistency throughout the state.

To this end, the General Assembly adopted the *American Medical Association Guides to the Evaluation of Permanent Impairment*, third edition revised, as the standard by which properly accredited physicians would evaluate and assign impairment ratings.

The impairment ratings, in turn, are based exclusively upon the claimant's medical condition. The impairment rating is then factored into a formula that ultimately determines the benefits to which the claimant is entitled. No consideration is given to the claimant's economic loss or the skills of his/her attorney, as under the old system. Thus, the previous adversarial process, in which a judge made such decisions, was abandoned in favor of a system in which the impairment, not the socioeconomic status or wage-earning potential of the worker, determines the compensation paid to the claimant.

Legal Framework

There are no federal or local laws or regulations addressing the accreditation of physicians under the workers' compensation system. Rather, such accreditation is addressed only in the Workers' Compensation Act of Colorado (Act), which can be found in Articles 40 through 44 of Title 8 of the Colorado Revised Statutes (C.R.S.).

The Act comprehensively prescribes the manner in which workers' compensation claims are to be handled, including, but not limited to, coverage and liability (Article 41); how and when benefits are to be assessed and paid (Article 42); employer notification procedures, settlement and hearing procedures, review procedures and utilization review and independent medical examination procedures (Article 43); and insurance requirements (Article 44). This sunset review, however, is confined to the physician accreditation system created in sections 8-42-101(3.5) and (3.6), C.R.S.

The Act directs the Director of the Division of Workers' Compensation (Director), to contract with the medical school at the University of Colorado for the services of a medical director, who shall be a Colorado-licensed medical doctor (Medical Director). The Medical Director advises the Director on issues of accreditation, impairment rating guidelines, medical treatment guidelines, utilization standards, case management, and consults on peer review activities. §8-42-101(3.6)(n), C.R.S.

The Act establishes a two-tier system for accrediting physicians who work with workers' compensation claimants based on whether the physician limits his/her practice to treatment or whether the physician conducts impairment evaluations.

A physician who provides primary care to claimants, who have, as a result of their work-related illness or injury, missed more than three days of work (time-loss injuries), may obtain Level I Accreditation. This level of accreditation is voluntary for Colorado-licensed medical doctors, doctors of osteopathy, doctors of dental surgery and doctors of podiatry. §§8-42-101(3.5)(a)(I) and (3.6)(a)(I), C.R.S. It is mandatory for any doctor of chiropractic who provides primary care to workers' compensation claimants. §8-42-101(3.6)(a)(I), C.R.S. A physician, including a doctor of chiropractic, who provides treatment for non-time-loss injuries, need not be accredited to receive reimbursement under the Act. §8-42-101(3.6)(i), C.R.S.

Only Colorado-licensed medical doctors and doctors of osteopathy may obtain Level II Accreditation. §8-42-101(3.5)(a)(I), C.R.S. Only a physician with a Level II Accreditation may conduct impairment evaluations of claimants. However, a physician need not obtain Level II Accreditation to determine that no permanent medical impairment has resulted from the illness or injury. §8-42-101(3.6)(b), C.R.S.

The Division has created, by rule, a Limited Level II Accreditation for those physicians who conduct impairment evaluations within their respective specialties. These physicians must pass only specified portions of the accreditation examination and are legally restricted to performing impairment evaluations relating to those specific areas. Division Rule XX(B)(5)(b).

The Division maintains a list, which is updated on a monthly basis, of all accredited physicians and those physicians whose accreditation has been revoked. §8-42-101(3.6)(k), C.R.S. This information is then shared with insurers, the public and the appropriate state licensing board(s).

The Director has established medical treatment guidelines and permanent impairment rating guidelines based upon the *American Medical Association Guides to the Evaluation of Permanent Impairment*, third edition revised (*AMA Guides*). §8-42-101(3.5)(a)(I) and (II), C.R.S., Division Rule XIX.

Regardless of the accreditation level sought, all physicians seeking accreditation must complete the appropriate Division-provided accreditation-training program. §8-42-101(3.6)(c), C.R.S., Division Rule XX(B)(1)(b). The training programs provide physicians with an understanding of the administrative, legal and medical roles of accredited physicians within the workers' compensation system. §8-42-101(3.6)(e), C.R.S. In addition, a physician seeking accreditation must submit an application to the Director, pay a fee, certify compliance with the Division's rules pertaining to accreditation and pass an examination at the conclusion of the accreditation-training program. Division Rule XX(B)(1). A physician is allowed three attempts to pass the Division's examination, and if he/she is unable to do so in three attempts, he/she must wait six months before attempting to do so again. Division Rule XX(B)(2). Accreditation begins on the date on which the physician passes the Division's examination. Division Rule XX(B)(3).

The registration fees for the training programs cover the costs of administering the program. §8-42-101(3.6)(l) and (m), C.R.S. The fee for Level I Accreditation may not exceed $250, and the fee for Level II Accreditation may not exceed $400. §8-42-101(3.6)(d), C.R.S. Regardless of accreditation level, all accreditations are valid for three years and may be renewed for successive three-year periods. §8-42-101(3.6)(f), C.R.S., Division Rule XX(B)(4). To renew an accreditation, the physician must submit an application to the Division, attend one of the Division's special renewal training programs and certify compliance with the Division's rules. Division Rule XX(C)(3).

The Director shall revoke a physician's accreditation for violations of the provisions of the statute or the rules and regulations promulgated thereunder. §8-42-101(3.6)(g), C.R.S. However, the Division's rules state that the Director *may*, with input from the Medical Director, revoke a physician's accreditation for refusal to comply with, or substantial failure to comply with, the Act and/or the Division's rules, the *AMA Guides*, the Division's medical treatment guidelines or the utilization standards adopted by the Director; a misrepresentation on the application for accreditation; where a reviewing panel has recommended revocation or upon a combination of two or more incident's heretofore described. Division Rule XX(D)(1).

Any such revocation hearings are held before an administrative law judge, who renders findings of fact, conclusions of law and recommendations to the Director, who shall enter an order in the case. §8-42-101(3.6)(g), C.R.S., Division Rule XX(D)(4). A physician who has had an accreditation revoked may appeal the revocation to the Industrial Claims Appeals Office and then to the Colorado Court of Appeals. §8-42-101(3.6)(g), C.R.S.

If a physician whose accreditation has been revoked submits a claim for payment of services that are rendered subsequent to the revocation, no insurance carrier or self-insured employer is under any obligation to pay such a claim. §8-42-101(3.6)(h), C.R.S. Similarly, no insurance carrier, self-insured employer or claimant is liable for the costs incurred for an impairment evaluation performed by a physician who does not hold a Level II Accreditation. §8-42-101(3.6)(o), C.R.S.

Finally, the Division may receive money from any governmental unit, as well as grants, gifts and donations from any source so long as they are not subject to any conditions that are inconsistent with any provision of the Act. §8-42-101(3.6)(q), C.R.S.

Program Description and Administration

Prior to the 1995 sunset review of the physician accreditation program (Program), the statutory provisions authorizing the Program also created a Medical Care Accreditation Commission (Commission) whose members were appointed by the governor. The primary mission of the Commission was to assist the Department of Labor and Employment, Division of Workers' Compensation (Division) in developing the standards and processes of the Program, including fee schedules, impairment rating guidelines, medical treatment guidelines and utilization standards. The Department of Regulatory Agencies' (DORA's) 1995 sunset report recommended that the Commission be abolished because it had accomplished its statutorily mandated duties. The General Assembly acted on this recommendation and sunset the Commission effective July 1, 1996.

However, the Division viewed the Commission as a valuable vehicle for input and policy debate. Without additional funding, the Executive Director of the Department of Labor and Employment (Department) now appoints individuals to the unofficial Medical Care Advisory Committee (Advisory Committee) based on recommendations of the Division Director and the Division's Medical Director. The composition of the Advisory Committee remains virtually identical to that of the Commission, in terms of representation.

The six-member Advisory Committee meets on a quarterly basis and devotes approximately one-third of its time and efforts to the Program. It is composed of three physicians, including a representative of the Colorado Medical Society and a chiropractor; one injured worker representative; one insurance carrier representative and one small business representative. In addition, members of the Division's staff also participate in the Advisory Committee meetings: the Division Director, the Division's Medical Director and other medical program managers.

The Advisory Committee continues to be involved in providing recommendations and input to the Division Director and Executive Director regarding workers' compensation issues, including, but not limited to, rulemaking and revising the Division's medical fee schedules, accreditation curriculum and medical treatment guidelines, but it does not possess any policy-making authority.

As the science of medicine continues to change, the need for up-to-date workers' compensation medical treatment guidelines remains. The Advisory Committee helps the Division accomplish this task.

License/Registration

The Program is entirely cash funded and receives funds through the imposition of fees. Surprisingly, the Program's fees remained constant from the date of inception in 1991, until 2001. Prior to January 1, 2001, the fee for Level I Accreditation was $150, and the re-Accreditation fee was $50. The fee for Level II Accreditation was $375, and the re-Accreditation fee was $325.

Effective January 1, 2001, however, these fees increased to $200 for Level I Accreditation, $150 for Level I re-Accreditation, $400 for Level II Accreditation and $350 for Level II re-Accreditation.

Since physicians must obtain re-accreditation every three years, rather than annually, these fees are not overly burdensome. In addition, the accreditation and re-accreditation fees also include the costs of attending the Division's accreditation and re-accreditation seminars and examinations, as the case may be.

As Table 1 illustrates, the Program is relatively inexpensive to operate. Over the course of the last five fiscal years, between three and five individuals have staffed the Program, bringing its average total full-time equivalent (FTE) employees to 2.5. Currently, the Program staff consists of a program manager, two clerical support staff members, an accreditation consultant and the Division's Medical Director.

Table 1
Program Expenditures

Fiscal Year	Total Expenditures	FTE
96-97	$178,880	2.5
97-98	$171,310	2.5
98-99	$288,044	2.5
99-00	$100,887	2.5
00-01	$128,498	2.5

Because physician re-accreditation is necessary every three years, rather than annually, the costs of the Program increase dramatically every three years, coinciding with the re-accreditation cycle for physicians who obtained accreditation when the program first began, and then fall again. From the table above, it is clear that fiscal year 98-99 was a big re-accreditation year. It is also logical to assume that fiscal year 02-03 will see a similar increase in expenditures.

Table 2 illustrates that the number of accredited physicians has slowly declined over the last five calendar years.

Table 2
Number of Accredited Physicians

Number of Accredited Physicians			
Calendar Year	Level I	Level II	TOTAL
1997	718	808	1,526
1998	630	836	1,466
1999	629	813	1,442
2000	589	819	1,408
2001	553	762	1,315

The Division attributes the steady decline in accredited physicians to the fact that most insurance companies focus on medical doctors and doctors of osteopathy as the primary care providers. Many of these insurance companies require these physicians to obtain Level II Accreditation in order to participate in their provider networks, regardless of whether they conduct impairment ratings. As a result, physicians who have smaller workers' compensation practices are less inclined to obtain accreditation.

The Division also attributes the decrease in the number of Level II-Accredited physicians to the fact that in 2000, Pinnacol Assurance, Colorado's largest workers' compensation insurance carrier, ceased requiring accreditation of specialists in its provider network who are not primary care providers (i.e., those who work on referrals only). As a result, many accredited physicians opted not to renew their accreditations.

In addition, the Division also offers a Limited Level II Accreditation to those specialists who perform impairment ratings only on certain body parts or systems within their respective specialties. In 1992, the Division concluded that although workers' compensation injuries often fall within certain, expected categories, these injuries continue to reflect the diversity of the workplace and may often be unusual. In order to ensure that injured workers are appropriately treated, regardless of the individual injury, the Program had to attract and retain physicians of all specialties. By offering limited accreditation, the Division has increased the pool of specialists because physicians seeking Limited Level II Accreditation are not required to attend the full Level II Accreditation seminar, and they take an accreditation examination that focuses on their respective areas of practice.

The figures in the table below indicate the number and area of specialty of Limited Level II Accreditations that the Division issued in calendar year 2001.

Table 3
Number and Specialty of Level II-Accredited Physicians
Calendar Year 2001

Medical Specialty	Full Accreditation	Limited Accreditation
Anesthesiology	4	0
Dermatology	0	1
Emergency Medicine	33	0
Family/General Practice	185	0
Internal Medicine	35	0
Manipulative Medicine	2	2
Neurology/Neurosurgery	5	36
NeuroPsychiatry	1	2
Occupational Medicine	95	0
Ophthalmology	0	9
Orthopedics - General	13	161
Orthopedics - Surgery	3	7
Otolaryngology	0	5
Pain Management	3	0
Physical Medicine & Rehab	86	0
Psychiatry	3	43
Pulmonary Medicine	2	3
Rheumatology	1	0
Sports Medicine	2	0
Surgery - General	4	0
Surgery - Hand	0	34
Surgery - Plastic/Reconstructive	4	2
Surgery - Plastic/Hand	0	5
Toxicology	2	0
TOTAL	483	310

The totals in Table 3 do not match the totals in Table 2 because physicians may elect to obtain limited accreditation in more than one specialty.

Finally, the public may locate accredited physicians by accessing the Division's web site.

Examination

Physicians obtain accreditation, either Level I or Level II, by attending a seminar and passing an examination. The curricula for both Level I and Level II seminars are developed by the Medical Director, who is the course director and an instructor at these seminars. Level I Accreditation and re-Accreditation seminars are daylong events. Level II Accreditation seminars span two days, but re-Accreditation seminars cover one and one-half days.

Seminar curricula are updated on a regular basis and re-accreditation curricula are completely revised every three years to include information regarding new treatment guidelines, new literature on treatment, findings from quality improvement studies and problems identified in performing impairment ratings. Course content and revisions thereto are evaluated by the Advisory Committee.

The seminars offered for Level I Accreditation are relatively mechanical in nature. The goal of these seminars is to familiarize the physician with the workers' compensation system, including the rules and procedures associated therewith and the Division's medical treatment guidelines. In addition, the seminar teaches the physician how to properly complete required paperwork to ensure that the injured worker obtains the treatment required in a timely and efficient manner, as well as to ensure timely and accurate payment to the physician.

The Level II Accreditation seminars are more complex. Because Level II-Accredited physicians perform impairment ratings based on the *American Medical Association Guides to the Evaluation of Permanent Impairment*, third edition revised (*AMA Guides*), physicians are taught how to employ the methods required by the *AMA Guides* in performing impairment ratings. The focus of these seminars is the method and process of how to perform an impairment rating. The goal is to better ensure that impairment ratings are performed as consistently as possible across the state, regardless of who performs the impairment rating and where it is performed.

Over the course of the last five years, the Division has conducted several seminars, for both Level I and Level II Accreditation, each year. Table 4 provides detail as to the number and types of seminars held over the course of the last five years.

Table 4
Frequency of Accreditation Seminars by Calendar Year

Type of Seminar	1997	1998	1999	2000	2001
Level I Accreditation/re-Accreditation	0	0	0	2	2
Level II Accreditation	3	1	2	1	1
Level II re-Accreditation	1	4	3	2	3

From 1997 through 1999, the Division did not offer any Level I Accreditation or re-Accreditation seminars. Rather, during those years, individuals were able to obtain accreditation via home study. This option is still available for Level I Accreditation and re-Accreditation. While Level II Accreditation and re-Accreditation may also be obtained via traditional home study, the Division has developed a Level II re-Accreditation program and examination that is available over the Internet.

Following each seminar, the appropriate examination is administered. The Level I Accreditation examination consists of 60 multiple-choice questions. While the examination is closed book and typically takes about one hour to complete, there are no time limits placed on examinees. Examination questions cover legal and administrative issues, causality, workers' compensation rules, medical treatment guidelines, billing and fee schedules, and prior-authorization issues.

The Level I re-Accreditation course requires physicians to complete a series of handwritten exercises throughout the course. These exercises cover the same topics as those addressed in the Level I Accreditation examination. For re-Accreditation, there is no formal examination, but the exercises are collected and evaluated, but are not used to deny re-Accreditation. Rather, if a physician appears to have a weak area, tutoring is provided.

The Level II examination is more involved and comprises a multiple-choice examination and an essay/practical examination. As with the Level I examination, there are no time limits associated with the Level II examination, although it must be completed in a single sitting.

The closed book, multiple-choice examination covers a variety of topics. All examinees, regardless of whether they are seeking full or limited accreditation, must answer the first 15 questions, which cover legal, ethical and administrative issues. The remaining questions must be answered depending upon whether the examinee is seeking full or limited accreditation. Candidates for full accreditation must answer all questions, whereas candidates for limited accreditation must answer only those questions that pertain to their declared specialties. The questions cover neurology, upper extremity, spine and lower extremity, vision, hearing, pulmonary and cardiovascular, dermatology and mental impairment. There are approximately five questions devoted to each topic.

Once the examinee completes the multiple-choice examination, he/she hands it in and obtains the essay/practical examination. The essay/practical examination presents medical cases, with appropriate data, for which the examinee must perform an impairment rating or provide other written information as required. Since this part of the examination requires research using the Level II curriculum and the *AMA Guides*, it is open book. Each question presents a medical case covering one of the medical subject-areas addressed on the multiple-choice examination. If the examinee is a candidate for full accreditation, all questions must be answered; if the examinee is a candidate for limited accreditation, only those questions that pertain to the candidate's declared specialty must be answered.

Table 5 illustrates the number of individuals who have taken each of the examinations over the course of the last five calendar years and the pass/fail rate for each year.

Table 5
Examination Information

Calendar Year	Number of Individuals Sitting for Initial Level I Examination	Pass / Fail Rate (%)		Number of Individuals Sitting for Initial Level II Examination	Pass / Fail Rate (%)	
1997	21	95.2	4.8	111	96.4	3.6
1998	39	92.3	7.7	74	78.4	21.6
1999	82	91.5	8.5	93	78.4	21.6
2000	133	91.7	8.3	53	84.9	15.1
2001	60	85.0	15.0	48	87.5	12.5

Due to data corruption and/or data entry problems, the Division reports that the numbers for the Level I examinations in 2000, and the Level II examinations in 1997, may not be accurate.

A standard look at the pass/fail rate does not paint an entirely accurate picture of the number of individuals who passed the relevant examinations. The Division allows individuals to retake the appropriate examination up to three times. On average, the pass rate for those who retake the Level I examination is 62.7 percent and 54.1 percent for the Level II examination.

Complaints/Disciplinary Actions

It is important to remember that neither Level I nor Level II Accreditation is required for a medical provider to treat injured workers. A treating physician may even declare maximum medical improvement without being accredited.

Regardless of whether a physician is accredited, a physician who treats injured workers must conform to the Division's rules for billing, reporting, utilization standards and utilization of the medical treatment guidelines. Both accredited and non-accredited physicians are subject to the internal (i.e., within the Division) and external (employer, insurance, and physician network) systems, which may directly or indirectly enforce compliance with Division rules. Some of these rules and procedures are self-enforcing -- if a physician does not submit certain specified documentation to the payor, the physician will not be paid.

Physicians are thus accountable to multiple enforcement mechanisms in the workers' compensation system. This results in a relatively consistent application of the standards, and, therefore, in a low number of formal complaints filed with the Program. Many non-medical constituents have become increasingly savvy in their assessment of medical issues such as whether a particular procedure falls within the treatment guidelines, or even whether an impairment rating was performed according to proper methodology. Therefore, insurers may often be able to address a problem about a medical report with the provider in question without involving the Division. As the workers' compensation system has matured since 1991, only the more complicated or consequential medical compliance issues are being brought to the attention of the Division for further intervention.

The Program's enforcement of compliance issues is primarily focused on educating and supporting physicians who work in the workers' compensation system. Because the Program's objective is to prepare physicians to function effectively in the workers' compensation system by learning and applying specialized knowledge and methods, the overriding interest is to maintain and enhance performance, as well as to maintain a diverse, accredited physician pool that can meet the needs of the system. To meet this objective, the Program prefers to tutor, counsel or take other, non-punitive action against accredited physicians who do not properly perform impairment ratings.

Complaints regarding individual, accredited physicians that are brought to the attention of the Program are reviewed and are handled on a case-by-case basis. For example, an injured worker or his/her attorney may submit a complaint about how the claimant was treated by the physician during an office visit. The complaint is forwarded to the physician with a cover letter from the Program's manager, and the physician is asked to provide a written response. The response received by the Division is then evaluated and may be forwarded back to the complaining party, with additional comment from the Program's staff. The Program's manager, with input from the Medical Director, will determine whether the identified problem is within the Program's oversight, and then either pursue additional investigation or close the matter. For example, while complaints about a physician's conduct during an office visit are infrequent, they almost always involve a patient care issue that more properly falls within the purview of the Board of Medical Examiners. In such instances, the complaining party is referred to the proper state agency.

Complaints that involve matters of impairment ratings are addressed in a variety of ways. The final impairment rating and/or date of maximum medical improvement given in a case may be questioned by either party to the claim (the employer or the employee). The statutory remedy is to have the claimant undergo an Independent Medical Examination (IME) by a different Level II-Accredited physician, who will issue an independent report. The IME-physician's report should explain his/her new rating (if any) and why there is agreement/disagreement with the treating physician's rating. The IME-physician's rating is final unless one of the parties further attempts to overturn the IME-physician's rating at a hearing on the basis of clear and convincing evidence, where an administrative law judge will review the evidence and issue

his/her findings as to permanent impairment. It should be noted that this manner of review does not necessarily reflect problems with the technical propriety of the rating (i.e., whether it was done correctly). A physician's clinical judgment plays a large role in patient care and the final evaluation process, and the parties often have their own reasons to challenge the treating-physician's or IME-physician's rating.

Occasionally, the Program receives complaints about a specific physician that suggest a pattern of problems in a specific area over which the Program has authority. For example, an attorney submitted to the Program part of a deposition transcript where it was clear that the physician-deponent misunderstood a vital part of the mental impairment rating process. In a case such as this, the Program will request information and documentation from the complaining party, including case-specific examples, and proceed to investigate. If the Division finds that the problems are substantive, it will contact the physician in writing, noting the nature of the problem and suggesting remedial tutoring. The physician has an opportunity to respond. Usually the remedial steps taken involve counseling the physician in-person (performed by one of the Program's consultants, the Medical Director, or both), and the requirement that the physician submit his/her final case reports to the tutor for review. Feedback will be provided to the physician as needed. If he/she completes this "probationary" period successfully, no further action is taken. If the physician is uncooperative, other actions may be considered, including revocation of accreditation or, if applicable, initiating removal from the IME physician panel (a pool of Level II-Accredited physicians who have been designated by the Director to perform IMEs).

In 2001, two physicians were subjected to this scrutiny. One was the deponent mentioned above, who complied with tutoring and completed the probationary period. The second physician had already been tutored several times in 2000, but his performance failed to improve. Since nearly all of the problem cases were in connection with his performance on the Division's IME panel, the physician was given the opportunity to resign from the panel before the Division pursued his involuntary removal. The physician elected to resign.

Table 6 illustrates the various types of actions taken by the Program over the course of the last five calendar years.

Table 6
Disciplinary Information by Calendar Year

Type of Action	1997	1998	1999	2000	2001
Cautionary Letter Regarding General IME Performance	2	1	N/A	2	3
Cautionary/Instructional Letter Regarding Violation of Rule or Statute	1	N/A	1	0	10
Admonition/Correction on Impairment Rating Methodology	4	3	N/A	1	4
Dismissals	4	1	N/A	5	5
Removal from IME Panel (voluntary or forced)	N/A	1	2	N/A	1
Revocation of Accreditation	0	1	0	0	0

Remarkably, the Division has only revoked the accreditation of a physician once in the last five years. Unless the circumstances are especially egregious and unusual, the process for revocation is not initiated until other efforts to achieve compliance have been attempted.

This is due, in part, to the fact that only actively licensed physicians may obtain and maintain accreditation. A physician may be dropped from the Division's accreditation list if he/she fails to renew his/her underlying professional license, or has an inactive or suspended license. The Division prefers to view this scenario as an administrative revocation, rather than a formal, disciplinary revocation.

To assist this process, the Division receives periodic electronic updates from the appropriate agencies in the Department of Regulatory Agencies (i.e., the Board of Medical Examiners) regarding addresses, phone numbers, and license status. The Program also receives monthly hard-copy advisories of physicians subject to actions affecting their licenses. If a lapsed, revoked or suspended license is noted, the Program advises the physician that it has received certain information about the professional license status; that based upon this information the physician's name will be removed from the Program's accreditation lists; and, if Level II-Accredited, the physician henceforth may not perform any impairment ratings.

The physician is given the opportunity to respond within 30 days if the information is incorrect or if he/she has other objections. To date, no physician has submitted an objection in the course of this particular process. If the three-year accreditation period itself has not lapsed in the interim, the physician's accreditation may be reinstated upon license reactivation or completion of the suspension period.

A physician's accreditation may also be revoked as a result of the Utilization Review process. A panel of three reviewers must unanimously recommend revocation to the Division Director, who considers the facts and recommendations presented, and then decides whether to forward the case to an administrative law judge for hearing. On only one occasion, in 1997, has a review panel recommended revocation. However, prior to the hearing, the physician in question voluntarily relinquished his Level I Accreditation, and the matter was closed.

Analysis and Recommendations

Recommendation 1 - Continue the Physician Accreditation Program until 2014.

The first sunset criterion asks whether regulation is necessary to protect the public health, safety and welfare. It is undisputed that the physician accreditation program (Program) does just that.

One of the primary goals of the Program is to achieve consistency among impairment ratings performed on injured workers. While it is difficult, if not impossible, to quantify such a performance measure, the Department of Regulatory Agencies' (DORA's) discussions with interested parties revealed that since the Program's inception, the quality and consistency of impairment ratings has increased dramatically. An injured worker in Craig can expect to receive the same, or substantially similar, impairment rating in Craig as in Denver or Vail or Pueblo. In this manner, the health, safety and welfare of the public are protected against the need for excessive litigation.

The first sunset criterion also asks whether the conditions that led to initial regulation have changed. The Program was created as part of Colorado's workers' compensation reform efforts in 1991. Prior to the inception of the Program, impairment ratings were more subjective than they are today. If an injured worker wanted to appeal the impairment rating, the worker hired a lawyer. The injured worker and the insurance carrier then went to court, where their lawyers and experts argued over the injured worker's true impairment rating. Ultimately, a judge decided the degree to which the injured worker was impaired.

Thus, as part of Colorado's reform efforts, the Program was created to lend a greater degree of objectivity to the process and remove most, if not all, such claims from the legal system. While it is not possible to quantify the degree to which this has occurred, anecdotally, the number of workers' compensation cases being appealed to the legal system has declined since the Program's inception.

Importantly, this has occurred in an atmosphere of continued litigiousness in our society. It is, therefore, reasonable to assume that if the General Assembly were to sunset the Program, the workers' compensation field would again become highly litigious.

Therefore, the General Assembly should continue the Program for an additional 11 years.

Recommendation 2 - Authorize the Director of the Division of Workers' Compensation to adopt, pursuant to the requirements of the State Administrative Procedure Act, the most appropriate edition of the "American Medical Association Guides to the Evaluation of Permanent Impairment." Amend section 8-42-101(3.5)(a)(II), C.R.S., as follows:

> **(A) IN ACCORDANCE WITH THE PROVISIONS OF ARTICLE 4 OF TITLE 24, C.R.S., THE DIRECTOR SHALL ESTABLISH WHICH EDITION OF THE "AMERICAN MEDICAL ASSOCIATION GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT" SHALL BE USED IN DETERMINING IMPAIRMENT RATINGS AS A PERCENT OF THE WHOLE PERSON OR AFFECTED BODY PART.**
>
> **(B) The director shall promulgate rules establishing a system for the determination of medical treatment guidelines and utilization standards and medical impairment rating guidelines BASED ON THE ~~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", SELECTED PURSUANT TO THE PROVISIONS OF THIS ARTICLE ~~in effect as of July 1, 1991~~.**

Amend relevant sections of the Colorado Revised Statutes to conform to this recommendation.

Currently, the Workers' Compensation Act specifies that the *American Medical Association Guides to the Evaluation of Permanent Impairment,* (*AMA Guides*), third edition revised, be used when conducting impairment ratings. However, the third edition revised of the *AMA Gu*ides was first published in 1990. In the meantime, the fourth edition was published in 1993, and the fifth edition was published in 2000. Thus, physicians who are accredited to perform impairment ratings in Colorado's workers' compensation system are basing those ratings on guidelines that have been superceded not once, but twice in the last 12 years.

In its 1995 sunset review, DORA recommended that the General Assembly adopt the fourth edition of the *AMA Guides*, which had just been published. This recommendation was the subject of considerable controversy for several reasons. First, the various editions of the *AMA Guides* have altered the manner in which impairment ratings on certain body systems should be conducted. As a result of these changes, the outcomes of impairment ratings could change, depending upon the edition of the *AMA Guides* that is used and the body system that is being evaluated. This could either increase or decrease the benefits that are paid to the workers' compensation claimant.

Second, some introductory language in the fourth edition specifically stated that the fourth edition was not intended to be used as the basis for determining monetary benefits. As a result, some states that had previously adopted the fourth edition were embroiled in lawsuits that challenged using that edition in such a manner.

Ultimately, the General Assembly elected to retain the third edition revised of the *AMA Guides* for use in Colorado's workers' compensation system. Unfortunately, the third edition revised is no longer in print. The Division must provide photocopies of it to candidates for accreditation.

An American Medical Association survey of all 50 states reveals that at least 12 states use the fourth edition and 20 states use the fifth edition. Only Louisiana uses the second edition. Seven states did not respond to the survey and nine reported that they use their own, state-specific guidelines.[3]

According to the same American Medical Association survey, only Colorado and Oregon continue to use the third edition revised. According to the Division of Workers' Compensation's Medical Director, Oregon does not actually use the third edition revised, but rather has developed its own guidelines that are based upon the third edition revised. This leaves Colorado as the only state that continues to use the third edition revised.

[3] *The Guides Newsletter*, November/December 2001 at 11.

In 2002, the Division commissioned a study to serve as the basis for determining whether Colorado should adopt a more recent edition of the *AMA Guides*. The research team selected 250 random case files from those cases that were filed with the Division, and conducted impairment ratings based on the information contained therein. All 250 cases were evaluated using the third edition revised, the fourth edition and the fifth edition of the *AMA Guides* to determine the difference in outcomes across the various editions and to conduct a cost-benefit analysis of the procedures required by each edition.

As of this writing, the Division had not yet finalized the report generated by this study, so it is not possible to determine whether it will recommend that Colorado should change to a more recent edition of the *AMA Guides*.

Even if the study demonstrates and recommends that Colorado change to a different edition of the *AMA Guides*, public input must still play a vital role in any ultimate decision. As the state's experts on workers' compensation, the Division is in the best position to weigh the costs and benefits of any change and to make the ultimate decision.

Directing an agency to adopt a statewide standard is not without precedent. The State Electrical Board is granted, in section 12-23-104(2)(a), C.R.S., the authority to adopt and revise the state electrical code, and the State Plumbing Board is granted, in section 12-58-104.5, C.R.S., the authority to establish the state plumbing code. Both of these provisions represent acknowledgements by the General Assembly that a standard is necessary, as in the workers' compensation system, and that the experts serving on the respective boards are in the best position to evaluate the benefits and costs of various codes and select the most appropriate code for use in Colorado.

While it may seem impersonal and callous to compare the *AMA Guides* to an electrical or plumbing code, it must be remembered that all three standards seek to impose consistency and to enhance the health, safety and welfare of the public.

In addition, this system affords these agencies the flexibility to adapt to changing technologies, methods and procedures. Public input is assured by making the decision-making process subject to the State Administrative Procedure Act.

Additionally, Colorado physicians already use the fifth edition of the *AMA Guides* when conducting impairment ratings in other contexts, such as determining disability benefits, processing automobile insurance claims and obtaining private disability insurance, to name a few. Thus, by retaining the third edition revised for use in the workers' compensation system, Colorado physicians who are accredited by the Division must learn and know both editions of the *AMA Guides*, which only increases the potential for error.

Finally, this recommendation does not advocate changing to the fourth or fifth editions of the *AMA Guides*. Rather, the General Assembly should authorize the Division Director to conduct hearings to determine which edition will best serve the needs of Colorado and then to adopt that edition.

Appendix A - 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 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 not 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; and

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

Appendix B – Physician Accreditation Statutes

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.

(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 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 maintained by the director.

(c) (I) This subsection (3.5) is repealed, effective July 1, 2003.

(II) Prior to such repeal 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 two-tier accreditation system shall be comprised of the following programs:

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

(b) A physician who provides impairment evaluation of injured workers shall complete and must have received accreditation under the level II accreditation program. However, the authorized treating physician providing primary care need not be level II accredited to determine that no permanent medical impairment has resulted from the injury. 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. All physicians who are required to be accredited shall complete the level II accreditation program or programs.

(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 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, 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 nor a 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) (Deleted by amendment, L. 96, p. 151, § 2, effective July 1, 1996.)

(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 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 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), neither an insurance carrier nor a self-insured employer or injured worker shall be liable for costs incurred for an impairment evaluation rendered by a physician where there is a determination of permanent medical impairment if such physician is not level II accredited 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) 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, 2003.

(II) Prior to such repeal 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.