DEPARTMENT OF LABOR AND EMPLOYMENT

DIVISION OF WORKERS' COMPENSATION

LEVEL I CURRICULUM

CHRONOLOGY OF A WORKERS' COMP CASE

CHRONOLOGY OF A TYPICAL WORKER'S COMPENSATION CASE

Objectives:

- Define an authorized treating physician.

Discuss the procedure for determining physical restrictions and work status.

Identify the four events that result in discontinuation of temporary disability payments.

Define Maximum Medical Improvement.

Define impairment and describe the difference between impairment and disability.

Explain the process for obtaining an impairment rating when the authorized treating physician is not Level II accredited.

CHRONOLOGY OF A TYPICAL WORKER'S COMPENSATION CASE

Reference to Rule, Statute, Etc.

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

§8-41-301, C.R.S.

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Worker reports incident symptoms to employer

§8-43-102(1)(a) and (2), C.R.S.

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Employer files a First Report of Injury form with insurance carrier

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

§8-43-103(1), C.R.S.

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

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

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

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Responsibilities of a physician at the first visit

1. Take a complete history including job duties, details regarding accident or hazardous exposure and related symptoms, additional past medical history, and history of non-occupational activities.

2. Perform a complete physical examination for all relevant body parts based on the history and patient complaints.

3. Render a diagnosis based on the above.

4. Determine whether the medical probability (greater than 50% likelihood) that the patient's condition is work related. (Causation will be explored in detail in the following chapter.)

5. If it is determined that the patient's condition is not work-related, explain to the patient that the employer is not liable for the cost of the care under workers' compensation. Care must continue under their general health care provide. If you find the condition to be work-related, continue your treatment plan.

Rules of Procedure, Rule 17

6. Order appropriate diagnostic studies and initial treatment (refer to relevant Colorado Division of Workers' Compensation Medical Treatment Guidelines).

7. Determine work and activity restrictions.

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

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

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

§8-42-105 & 106, C.R.S.

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

§8-42-105(2)(d), C.R.S.

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

§8-42-105(1), C.R.S.

§8-42-106(1), C.R.S.

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

§8-42-105(3), C.R.S.

Complete the WC164 form ("Physician's Report of WC Injury"), submit to the payer within **14 days** of the date of service, and supply a copy to the patient.

Rule 16-7(E)

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Follow-up patient visits

1. Continue diagnostic tests and treatment as necessary.

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

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

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

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

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

Rules of Procedure, Rule 16-7(E)

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Determination of Maximum Medical Improvement (MMI)

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

§8-40-201(11.5), C.R.S.

Temporary total disability payments will cease at MMI.

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

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

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Patient at MMI

Authorized treating physician completes WC164 form ("Physician's Report of Workers' Compensation Injury") and submits to insurer and patient.

Rules of Procedure, Rule 16-7(E)

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

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

§8-42-105(3)

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

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

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

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

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

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

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

ETHICAL CONSIDERATIONS

"To Whom Am I Responsible in the Workers' Compensation System?"

Objectives:

Review the procedures for release of medical records in workers' compensation cases.

Describe medical/ethical issues pertaining to workers' compensation cases.

Discuss the role of case management in workers' compensation.

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

	REFERENCES
1. To whom do you owe primary responsibility at all times? ❑ The State of Colorado Workers' Compensation System. ❑ The employer who designated you as the workers' compensation provider. ❑ The insurance company whose network you belong to. ❑ The patient.	ACOEM Code of Ethics
2. What is your current policy for medical record release in the following two situations? a. An insurer requires a copy of your medical records to justify your billing level. Your office ❑ Copies and sends the complete narrative report. ❑ Sends the physician's complete narrative report if the patient signed a medical record release form for billing purposes. ❑ Notifies the patient in writing that the physician's complete narrative report will be sent to the insurer.	Interprofessional Code of Ethics

		REFERENCES
	b. You are treating a patient for a work-related low back injury. In the course of taking the initial history you note that the patient has been treated for depression multiple times in the last ten years and has a 20-year history of schizophrenia. The patient is currently taking medication for the schizophrenia. The employer requests a copy of physician's initial narrative report, which contains this psychiatric history, in order to determine whether they wish to challenge the work-relatedness of his condition. Your office ❑ Copies and sends the complete narrative report with the physician's initial report. ❑ Sends the physician's complete narrative report if the patient signed a medical record release form for billing purposes. ❑ Notifies the patient in writing that the physician's complete narrative report will be sent to the employer. ❑ Sends the complete narrative report to the employer if the patient has signed a specific release to the employer allowing release of psychological information.	ACOEM Code of Ethics Chiropractic Standard of Ethics Interprofessional Code of Ethics 3.3 and 2.1 Statute §8-43-404(4)
3.	**In a workers' compensation claim, an employer is entitled to which of the following records when no medical record release form has been signed by the patient? Check all that apply.** ❑ Complete medical records including history of past medical illnesses that are unrelated to injury. ❑ Current information regarding diagnosis, detailed treatment plans and names of consultants. ❑ Information in the medical record directly related to the workers' compensation claim. ❑ Work restrictions and time off work information.	ACOEM Code of Ethics Statutes §8-47-203(1) §8-43-404(4)
In general if your office is abiding by current medical record release laws the same procedures can be followed in workers' compensation.		

	REFERENCES
4. Practical problems with confidential communications. You are the patient's primary care physician or chiropractor and also the designated workers' compensation physician for a school district where the patient is employed as the secretary. The secretary suffers a back injury at work. Should prior, <u>non-work related</u> low back treatment records be automatically provided to the workers' compensation carrier? ÍYES ÍNO	ACOEM Code of Ethics Statute §8-47-203(1) §8-43-404(4)
An independent nurse case manager hired by your patient's workers' compensation insurer contacts you by phone. The patient is represented by an attorney. You are asked to discuss the patient's current work status including restrictions, compliance with the current treatment plan, and any abnormal pain behaviors you have observed while examining the patient. You should (check all that apply) ❑ Discuss all of the above topics with the nurse case manager because the workers' compensation statute waives any protection. ❑ Limit the discussion to work restrictions and place a note in the patient's chart. ❑ Talk to the patient before having any discussion with the case manager. ❑ Do not discuss any topics with the nurse case manager because you have no release from the patient. ❑ Do not discuss the case because the patient is represented by an attorney.	Statutes §8-42-101(3.6)(p)(I)(A) and §8-42-101(3.6)(p)(II) American Chiropractic Association of Code of Ethics Colorado Chiropractic Practice Act §12-33-126, C.R.S. Colorado Board of Chiropractic Examiner Rules and Regulations Statute §25-1-802(1) Interprofessional Code of Ethics
You perform an independent medical exam on a workers' compensation patient. You should send the report: ❑ Only to the party that hired you. ❑ To the patient, their attorney, and the workers' compensation insurer or employer.	Statute §8-43-404(2)

CAUSALITY

Determining Causality in Workers' Compensation

Objectives:

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

DETERMINING CAUSALITY IN WORKERS' COMPENSATION

Risk-Assessment or Causal Relationships in everyday life

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

Causality Assessment in Medicine

Case #1 55 year old overweight male with HTN presents with severe back pain.
Case #2 25 year old female presents with severe low back pain.

Differential diagnosis

Case #1	abdominal aneurysm
Case #2	pelvic pathology

Workers' Compensation Causality

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

Causation Assessment

1. Record an occupational medical history including a detailed description of the incident reportedly causing the injury or a complete job description of all activities which could have contributed to the patient's symptoms. The description of job duties should include a list of physical activities required, the duration and frequency of these activities and the total time the individual has worked in the job position. At a minimum, the job activities description should consider specific hand tool use, driving or other skilled activities, approximate lifting estimations, description of the posture required in order to complete the job tasks and consideration of the force necessary for the job tasks.

2. Take a complete medical history including medical diseases past and present, and non-occupational activities which could have affected the

complaint. Include hobbies involving the hands for upper extremity complaints and weekend sports activities for musculoskeletal injuries.

3. Establish a differential diagnosis for the patient using the complete history, physical exam findings, and the results of any preliminary diagnostic testing.

4. Assess the medical probability of the relationship between the assumed diagnosis and the work-related exposure.

Case Examples

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

Diagnosis is uniformly associated with asbestos exposure.

Asbestos exposure was common in this occupation.

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

Diagnosis possible medial collateral ligament strain.

Mechanism of injury – employee is not sure.

#3 Secretary develops carpal tunnel.

Risk Assessment Method

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

1. Strength of the association: The study should show a significant relative risk for developing the disease in question when populations are exposed at a specific exposure level.

2. Consistency of the evidence: Studies with different populations exposed to similar work exposures should produce the same result.

3. Specificity of the result: Studies should be sufficiently controlled to prove that the exposure was the cause of the diagnosis, rather than other confounding exposures or disease entities.

4. Temporal Relationship: The timing of the study and follow-up investigation of the workers should be sufficient to identify the disease in question. Long latency disease studies should exclude those cases occurring too early to be related to the exposure identified in the study.

5. Biological gradient: Studies should show that the greater the exposure, the greater the likelihood of a particular disease or injury. In some cases the phenomenon is "all or none" and no gradient can be present.

6. Coherence: The proposed exposure should be biologically plausible and consistent with previous research. Naturally when an entirely new causal relationship is discovered, initial reports will not necessarily conform with previous literature on the subject.

Workers' Compensation Statutes

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

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

Pre-Existing Medical Condition

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

Egg shell skull case in legal theory.

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

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

Using Risk Assessment

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

1. The worker claims to have irritant-induced reactive airway disease.

2. The worker claims the formaldehyde aggravated his pre-existing asthma.

How would you prove or disprove these assertions?

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

Activities of Daily Living

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

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

Isolated Mental Impairment (no physical injury)

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

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

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

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

STEPS IN CAUSALITY DETERMINATION	
1.	**Establish diagnosis (or differential diagnosis if further testing required)**
2.	**Define Injury or Exposure** For Exposures include ❖ Length of exposure ❖ Level of exposure (actual lifting required, amount of repetitive motion, special tool use, etc.) ❖ Comparison of workers' exposure to that of the normal population
3.	**Discuss Intervening Factors** Concurrent non-work-related injuries or disease processes, pre-existing impairment, or disease related activities outside of work, sports, hobbies, etc.
4.	**Explain any scientific evidence supporting a cause and effect relationship between the diagnosis and the exposure or injury**
5.	**Assign a medical probability level to the case in question** ❖ Medically probable >50% likely ❖ Medically possible ≤ 50 likely

Workers' Comp Rules & Guidelines

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

Objectives:

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

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

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

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

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

Accreditation is for 3 years

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

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

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

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

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

Musculoskeletal Committee

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

Purpose of the Medical Treatment Guidelines

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

Provider's Responsibilities Under the Guidelines - Rule 17

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

Payment for Care - Rule 17

Prior authorization unnecessary if treatment is within the guidelines and prior authorization is not required by Rule 16.

If payer questions care under the guidelines, they must refer to the specific section of the guidelines.

Creation of the Treatment Guidelines

Combination of evidence and consensus.
Peer Group Based – specialist from all disciplines who would treat the medical problem.

Current Guidelines [1993-2007]

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

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

1. **Education** – patient education on self-management of symptoms and prevention. Also includes education of employers, insurers, and family.

2. **Treatment Duration**
   - Begins at initiation of treatment
   - Time to effect - if no effect within limits change treatment or reassess diagnosis
   - Optimum duration - best duration for most cases
   - Maximum duration should not exceed this limit.

3. **Active Interventions**
Passive and palliative treatment only to facilitate active rehabilitation, therapeutic exercise and functional treatment.

4. **Active Therapeutic Exercise**
To improve strength, endurance, coordination, vocational duties.

5. **Positive Patient Response**
Defined by functional gains; e.g., positional tolerance, range of motion, and activities of daily living.

6. **Re-evaluate every 3-4 weeks**
If no positive patient response re-evaluate diagnosis or treatment.

7. **Surgery**
   - For functional gains not purely pain relief
   - Positive correlation of clinical findings, clinical course and diagnostic tests
   - Presence of a pathologic condition

8. **Six-month time frame**
As many as 50% are unlikely to return to work if out for 6 months or more.

9. **Return to Work**
   - This is part of therapy
   - Careful detailed restrictions must be written e.g. – lifting, pushing, pulling, kneeling, driving, tool use, cold environments
   - Be sure you understand patient's job before return to <u>full</u> duty. If unsure obtain advice of occupational professional.

10. **Delayed Recovery**
   - If no progress at 6-12 weeks consider psychosocial evaluation and interdisciplinary treatment.
   - 3-10% of patients will fall outside of guidelines for additional treatment. The physician must justify additional treatment showing functional gains.

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

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

Organization of the Guidelines:

Initial Diagnostic Procedures
- Hx and PE
- Initial Tests

Follow Up Diagnostic Imaging and Tests

Non-Operative Therapeutic Measures
- Manipulation
- Medication
- Education
- Exercise
- Physical Therapy
- Psychosocial Intervention
- Interdisciplinary Treatment
- Vocational Assessment and Rehabilitation

Operative Procedures

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

GENERAL GUIDELINE PRINCIPLES – Example from Chronic Pain Disorder Guideline

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

1. **APPLICATION OF THE GUIDELINES** The Division provides procedures to implement medical treatment guidelines and to foster communication to resolve disputes among the provider, payer and patient through the Worker's Compensation Rules of Procedure. In lieu of more costly litigation, parties may wish to seek administrative dispute resolution services through the Division or the office of administrative courts.

2. **EDUCATION** of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of chronic pain and disability. Currently, practitioners often think of education last, after medications, manual therapy, and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers, and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.

3. **TREATMENT PARAMETER DURATION** Timeframes for specific interventions commence once treatments have been initiated, not on the date of injury. Obviously, duration will be impacted by patient compliance, as well as availability of services. Clinical judgment may substantiate the need to accelerate or decelerate the timeframes discussed in this document.

4. **ACTIVE INTERVENTIONS** emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

5. **ACTIVE THERAPEUTIC EXERCISE PROGRAM** Exercise program goals should incorporate patient strength, endurance, flexibility, coordination, and education. This includes functional application in vocational or community settings.

6. **POSITIVE PATIENT RESPONSE** Positive results are defined primarily as functional gains that can be objectively measured. Objective functional gains include, but are not limited to, positional tolerances, range of motion (ROM), strength, endurance activities of daily living cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.

7. **RE-EVALUATION OF TREATMENT EVERY 3 TO 4 WEEKS** If a given treatment or modality is not producing positive results within 3 to 4 weeks, the treatment should be either modified or discontinued. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.

8. **SURGICAL INTERVENTIONS** Surgery should be contemplated within the context of expected functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic conditions.

9. **SIX-MONTH TIME FRAME** The prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return to work within a six-month timeframe, whenever possible. It is important to note that timeframes may not be pertinent to injuries that do not involve work-time loss or are not occupationally related.

10. **RETURN-TO-WORK** is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific written physical limitations and the patient should never be released to "sedentary" or "light duty." The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, overhead work, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated.

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

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

12. **GUIDELINE RECOMMENDATIONS AND INCLUSION OF MEDICAL EVIDENCE** Guidelines are recommendations based on available evidence and/or consensus recommendations. When possible, guideline recommendations will note the level of evidence supporting the treatment recommendation. When interpreting medical evidence statements in the guideline, the following apply:

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

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

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

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

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

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

BILLING
and
ADMINISTRATIVE PROCEDURES

Billing Information

Objectives:

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

Billing for Workers' Compensation

Introduction:

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

In 2008, ***effective January 1, 2009***, the Division of Workers' Compensation adopted revisions to 7 CCR 1101-3, Rule 18 (MFS) and incorporated the 2008 edition of the RVP© for payments of medical services, the Current Procedural Terminology CPT® 2008 for codes, descriptions, parenthetical notes and coding guidelines unless modified by rule and the Medicare Severity Diagnosis Related Groups (MS-DRGs) Definitions Manual for inpatient hospital stays. In addition, the Director's Interpretive Bulletin No. 13, available on the Division's webpage (www.coworkforce.com/DWC/), provides clarification of codes, a listing of the Division created codes with descriptors and relative value units (RVUs) for codes missing RVUs in the RVP© and further explanations relative to billing for medical services.

Each year the Division's Medical Cost Containment (MCC) unit conducts an evaluation of the fee schedule and the applicable conversion factors listed in Rule 18. The Division has been charged to create this fee schedule in an attempt to control the costs involved in workers' compensation cases. Therefore fees can change on an annual basis. You must reference Rule 18 each year to stay abreast of any changes. To evaluate the cost impact of updating or changing fee schedules, the MCC determines the budget neutral conversion factor for the several sections of Rule 18.

Budget Neutral Conversion Factor

A conversion factor (CF) is a dollar amount used to turn the RVUs listed in the fee schedule into a dollar amount for the service rendered. Since reimbursement amounts may be impacted by changes to the American Medical Association's (AMA) copyrighted Current Procedural Terminology (CPT®) system, the assigned RVUs, restrictions in the RVP©'s guidelines and the conversion factor, it is necessary to start by determining a "budget neutral" conversion factor. Changes to CPT® coding and the RVUs are outside the domain of the Division. A "budget neutral" conversion factor is a base-line calculation to determine the conversion factor needed to result in a zero percent change in cost between two fee schedules. The "cost" for the current fee schedule is relative to the frequency with which codes are billed and any modifiers associated with those codes. By using those frequencies and the cost generated, a comparison can be made to the new fee schedule. Because the various sections of the fee schedule have different conversion factors, the budget neutral conversion factor is calculated section by section.

A simplified formula for calculation of the current fee schedule costs:

Frequency (of billing code) x RVU x current CF = Cost

To determine a “budget neutral” CF, the equation becomes:

Cost (from above) / [frequency x new schedule’s RVUs] = budget neutral CF

Rule 16

Rule 16 defines the standard terminology, administrative procedures and dispute resolution procedures in workers' compensation. Rule 16-1 requires all providers and payers to use Rules 16, 17 (MTG) and 18 (MFS). Rule 16-2 gives standard terminology for Rules 16 and 18. To be eligible for reimbursement under Workers' Compensation, a medical provider must be an authorized treating provider as defined in Rule 16-2(B). Rule 16-3 prohibits payers from dictating the type or duration of medical treatment or imposing their own internal guidelines or standards for medical care that conflict with Rule 17. Rule 16-4 establishes that payers use the Medical Fee Schedule to determine maximum allowable fees. All non-physician providers must have a referral to establish their authorized classification for reimbursement. Rule 16-5 lists Division recognized health care providers. Any medical provider not listed in Rule 16-5 must have prior authorization from the payer before providing services.

Out-of-State Providers

In the event the injured worker moves out-of-state or is referred to an out-of-state provider, the explanation of the necessary procedures is outlined in Rule 16-5(B). Referrals to out-of-state providers must comply with Rule 16-5(B)(2). The referring physician must accept the responsibility for complying with the 5 requirements listed therein.

Out-of-state providers should be advised that the billing codes and reimbursement levels are limited to the Colorado workers' compensation fee schedule (Rule 16-5(B)(3)).

Billing Rates and Fees

Effective January 1, 2009, reimbursement for medical services shall not exceed the amount allowed by the 2008 edition of the RVP© or the billed amount whichever is less. Some codes in the RVP© have yet to be assigned RVUs, and in some cases the Division may have established different values. Check the Director's Interpretive Bulletin 13 to see if there are recommended values. If there are none or you are billing for a service not identified in the fee schedule, you must first get prior authorization from the payer. Since the payer is to establish a value for these services by considering the complexity, time, level of training and expertise required to perform the service, you have the right to request their methodology.

Required Billing Forms

All billed services shall be itemized on the appropriate billing form (professional services use CMS 1500 (08-05), (Rule 16-7(B)(1)), with the appropriate billing codes and modifiers from the fee schedule (Rule 16-7(C)). Any services not billed on the proper

forms or using the appropriate billing codes may be contested until the provider complies (Rule 16-7(D)).

In addition to the appropriate billing form, the provider shall submit accompanying documentation (Rule 16-7(E). Initial contact with the patient is billed using the "Physician's Report of Workers' Compensation Injury" (WC164 – initial). This form requires completion of items 1-7 and item 10. Certain information, such as the insurer's claim number, may not be known and can be omitted. You are required to supply the injured worker with a legible copy of all WC164s at the time of completion and at no charge. In addition, the WC164 shall be submitted to the payer no later than fourteen (14) days from the date of service. All supporting documentation shall be submitted to the payer at the time of billing unless other agreements have been established. This documentation shall include copies of the examination, surgical, and/or treatment records.

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

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

Rule 16-8 sets forth the minimal requirements for medical record documentation.

Prior Authorization

The rules for obtaining prior authorization and how to proceed if authorization is contested are contained in Rule 16-9 and 16-10. In addition to procedures *not* listed in the Fee Schedule, Rule 17 (Treatment Guidelines) and Rule 18 (Fee Schedule) specifically identify some procedures *requiring* prior authorization.

In general, prior authorization for payment is requested when:

(1) A prescribed service exceeds the recommended limitations set forth in the MTG

(2) The MTG otherwise require prior authorization for that specific service

(3) A prescribed service is identified in Rule 18 as requiring prior authorization or where the service will exceed a given limitation.

(4) A prescribed service is not identified in the fee schedule (see Rule 16-9).

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

To complete a request, the provider shall concurrently explain the medical necessity of the service and provide relevant supporting medical documentation. Supporting medical documentation is defined as the documents used in the provider's decision-making process to substantiate the need for the requested service.

Hint: When you receive verbal prior authorization from the payer, send a form letter or e-mail addressed to the person who granted the prior authorization and state:

"As per our phone conversation of today (date), it is my understanding you have granted prior authorization for . . ." list the patient's name, workers' compensation number, carrier's claim identification code (if you know it or can get it from the person giving authorization), any approval authorization code provided and then specify the treatment approved (the procedures, frequency, etc.) and specify a time line for confirmation: "If I do not hear from you in writing within 7 days, I will assume my understanding is correct."

If the payer wishes to deny prior authorization they must comply with Rule 16-10.

Rule 16-9(H) Lack of prior authorization:

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

Contest of Prior Authorization

If you have complied with the rules for prior authorization but the payer does not respond in a timely manner, Rule 16-10(E) states:

> Failure of the payer to timely comply in full with the requirements of Rule 16-10(A) or Rule 16-10(B) shall be deemed authorization for payment of the requested treatment unless a hearing is requested within the time prescribed for responding as set forth in Rule 16-10(A) or (B) and the requesting party is notified that the request is being contested and the matter is going to hearing.

Payers may deny authorization for non-medical or medical reasons. Non-medical reasons could be because compensability of the claim has not been established; the billed services are not related to the admitted injury, the provider is not authorized to treat (referral), the employer may not have been covered by the carrier at the time of the

injury, or the billed code does not appear to be accurate based upon the information submitted.

When a payer wishes to deny prior authorization, the following, from Rule 16-10 must be followed:

(A) If the payer contests a request for prior authorization for non-medical reasons as defined under this Rule 16-11(B)(1), the payer shall notify the provider and parties, in writing, of the basis for the contest within seven (7) business days. A certificate of mailing of the written contest must be sent to the provider and parties.

If an ATP requests prior authorization and indicates in writing, including their reasoning and relevant documentation, that they believe the requested treatment is related to the admitted workers' compensation (WC) claim, the insurer cannot deny based solely on relatedness without a medical review as under Rule 16-10(A).

(B) If the payer is contesting a request for prior authorization for medical reasons, the payer shall, within seven (7) business days of the completed request:

(1) Have the request reviewed by a Physician or other health care professional, as defined in Rule 16-5(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review; and
(2) The reviewing provider may call the requesting provider to expedite communication and processing of prior authorization requests. However, the written contest or approval still needs to be completed within the specified seven (7) days under this Rule 16-10(B).
(3) Furnish the provider and the parties with either a verbal or written approval, or a written contest that sets forth the following information:

(a) An explanation of the specific medical reasons for the contest, including the name and professional credentials of the person performing the medical review and a copy of the medical reviewer's opinion;
(b) The specific cite from the division's MTG exhibits to Rule 17, when applicable;
(c) Identification of the information deemed most likely to influence the reconsideration of the contest when applicable; and
(d) A certificate of mailing to the provider and parties.

The Appeal of a Denial

Rule 16-10(C) Prior Authorization Disputes

(1) The requesting party or provider shall have seven (7) business days from the date of the certificate of mailing on the written contest to provide a written response to the payer, including a certificate of mailing. The response is not considered a "special report" when prepared by the provider of the requested service.
(2) The payer shall have seven (7) business days from the date of the certificate of mailing of the response to issue a final decision, including a certificate of mailing to the provider and parties.

If Continued Denial . . .

In some cases, the provider and the payer may not be able to come to an agreement. In such situations, the patient needs to rely on Rule 16-10(C) and approach the Division to request an expedited hearing:

(C) Prior Authorization . . .

(3) In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.

Hearings can take time, so keep in mind the following rules from Rule 16-10:

(D) An urgent need for prior authorization of health care services, as recommended in writing by an authorized treating provider, shall be deemed good cause for an expedited hearing.

(E) Failure of the payer to timely comply in full with the requirements of Rule 16-10(A) or Rule 16-10(B), shall be deemed authorization for payment of the requested treatment unless a hearing is requested within the time prescribed for responding as set forth in Rule 16-10(A) or Rule 16-10(B) and the requesting provider is notified that the request is being contested and the matter is going to hearing.

(F) Unreasonable delay or denial of prior authorization, as determined by the Director or an administrative law judge, may subject the payer to penalties under the Workers' Compensation Act.

Payment of Medical Benefits

Rule 16-11(A)(1) requires medical providers to submit their bills within 120 days of the date of service. The payer has 30 days [Rule 16-11(A)(2)] from the date of receipt to

either pay the bill or give justification as to why they are not. The date of receipt can be determined by the payer's date stamp or electronic acknowledgement date. Otherwise, receipt is presumed to be 3 days after date the bill was mailed. Because of these timelines, providers should double-check the address to assure they are mailing to the correct office.

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

In cases where the payer is not in compliance with the timely payment rules, the provider should first attempt to resolve the issue with the payer. If the problem of timely payment persists, the provider may seek the assistance of the Division's Carrier Practice Unit.

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

Name of the injured worker,
Date(s) of service in question,
Any identifying numbers for the claim,
Reference to the specific bill and each item being contested,
Reason(s) for contesting the payment including:
Citing of appropriate statutes, rules and/or documents supporting Payer's reasons for contesting payment and
Notice that the billing party may resubmit the bill or corrected bill in sixty days.

If the problem is the use of an incorrect CPT® code, the payer may contact the provider and with the provider's agreement change the code [Rule 16-11(B)(4)]. The explanation of benefits (EOB) accompanying the check shall include the name of the person at the provider's office who made the agreement. If there is no agreement upon a code, the payer may deny payment in accordance with the rules for contesting bills. [Rule 16-11(B) and (C)]

When contesting payment for medical reasons, the payer shall have the contested item(s) reviewed, within 30 days of receipt of the bill, by a physician or other healthcare professional holding a license and in the same or similar specialty as would typically manage the item under review. The reviewer may call the provider to expedite the process, however, the written contest of payment is still due within the 30 day period.

Upon completion of the review, the payer shall provide the provider and all parties involved with the following information:

(1) An explanation of the specific medical reason(s) for the decision,
(2) The name and credentials of the professional performing the review and a written copy of the reviewer's opinion
(3) Specific cites to any references to the Medical Treatment Guidelines (Rule 17)
(4) The identification of information the reviewer believes most likely to influence the reconsideration of the contest, and
(5) A certificate of mailing.

The medical provider has 60 days to appeal the contest of payment. Upon receipt of the resubmission, the payer has 30 days to process the appeal. If the contest of payment continues, the provider may approach the Division of Workers' Compensation, Medical Policy Unit for assistance. When approaching the Division, the provider should be prepared to submit a copy of the bill with the contested codes and dates of services in dispute, a copy of the payer's explanation as to why the billed services are being contested and a copy of any applicable medical record documentation.

Retroactive Adjustments of Medical Bills

Rule 16-11(E) limits the retroactive adjustment of payments. All medical bills are considered final unless such adjustments are made within twelve months after the date of the original EOB. In those cases where an adjustment is sought prior to the twelve month period, the written notice must contain a complete and specific explanation of the amounts being recovered, the specific reasons why these amounts are believed to be overpayments and evidence that these payments were in fact made to the provider. The provider has at least 60 days to respond to the written notice before any recovery is started.

Rule 16-11(G) requires contracts between providers and payers to comply with Rule 16-11.

Rule 18

Billing with the Fee Schedule

Once the diagnosis has been determined and the treatment protocol has been developed, the provider is faced with the gauntlet of seeking reimbursement for his/her services. This requires the submission of the CMS 1500 (08-05), adherence to the guidelines within the RVP©, the Division's adopted fee schedule, and Rules 16, 17 and 18.

Modification to the RVP©

Rule 18-5 lists certain instructions and modifications made by the Division to the RVP©. Interim values, indicated by an "I" in the left-hand margin for the RVP©, are accepted as a basis of payment; however deleted codes, marked by an "M", are not. Temporary codes listed in the RVP© may be used for billing if you have a prior agreement with the payer. Payment should be in compliance with Rule 16-6(B).

Fee Schedule Calculations

To properly bill for services, providers need to use the codes currently in effect for workers' compensation cases. The use of improper codes will result in the carriers returning the bills for re-coding. These codes and their RVUs are found in the RVP©, Rule 18 itself (Division created codes), and the Director's Interpretive Bulletin (No. 13) for the respective year.

As stated at the beginning of this section, the RVP© is available from Ingenix® located in Salt Lake City, Utah. Official copies of the rules can be ordered from LexisNexis Matthew Bender & Co., Inc., in Albany, NY. Unofficial copies of the rules and the Director's Interpretive Bulletin are available on the Division's webpage at www.coworkforce.com/DWC/ .

When billing for services rendered, the CPT® code must be related to one of the diagnostic codes (ICD-9) listed in *Item 21: Diagnosis or Nature of Illness or Injury* section of the CMS 1500 (08-05). The workers' compensation fee schedule is a "maximum fee schedule," meaning the carrier will reimburse the provider either the amount billed or the fee schedule amount, whichever is less. Providers should bill their usual and customary amount. To verify payments received, the provider must multiply the relative value units times the conversion factor for the respective code as established in Rule 18, taking into consideration any modification of the amount due to modifiers (to be discussed later). The codes from the RVP© and the respective CFs divide into the following sections for purposes of calculating reimbursement:

		(Eff. 1/1/09 – per RVU)
Anesthesia		$49.87
Surgery		$92.79
Surgery X Codes	see Rule 18-5(D)(1)(d)	$38.07
Radiology		$17.43
Pathology		$12.99
Medicine		$ 7.56
Physical Medicine		$ 5.57
E&M		$ 8.81

Thus the reimbursement for a new patient E&M code, as listed in RVP©, 2008 edition, would be calculated by:

6.5 (RVUs) x $8.81 (E&M CF from Rule 18-4.) = $57.27 (maximum allowed reimbursement)

Time Based Procedures

Certain codes are time based and require an additional step. For instance, a code listed as 8.0 units per 15 minutes must include under the Unit/Day column of the CMS 1500 (08-05) the number of 15 minute periods used. Treatment for 45 minutes with a 15-minute based unit value would show the number 3 in the "Unit/Day" column of the CMS 1500 (08-05) and be calculated by:

[8.0 (RVUs per 15 minutes) x 3 (number of 15 minute periods)] x CF (respective area) = maximum reimbursement.

Modifiers

Numeric modifiers may impact the reimbursement level. The RVP© contains a complete list of the modifiers on pp. 18-24. A modifier –26 indicates the provider is billing only for the professional component and requires the use of the RVUs listed for that modifier in the RVP©. The respective sections of the RVP© provide explanations of the professional and technical (modifier –TC) components of codes. Other common modifiers are:

-51 indicates multiple procedures at the same session by the same provider. For surgery this will result in a reimbursement level of 50% of the fee schedule value for all multiple procedures. In other words, the primary surgical procedure should not be marked with a -51 modifier. Any other non add-on surgical procedures would be marked with it and the resulting payment for those procedures would be 50% of the fee schedule allowed amount. This is discussed in the RVP's © surgery guidelines.

-80 indicates the provider was the assistant surgeon on this code and is reimbursed 20% of the allowed fee schedule amount

-81 indicates a minimum assistant surgeon's service and is reimbursed 10% of the fee schedule allowed amount.

As stated above, multiple surgery guidelines allow 100% of the allowed amount for the primary service and 50% for all others. For the assistant surgeon this would be 100% of the 20% allowed for the primary, and 50% of the 20% allowed for all other procedures.

Global Period

Global period is a term most commonly seen in surgery and refers to the pre- and post-operative time period. Once the decision for surgery has been made, all E&M (office) visits are considered to be included in the surgical fee. Thus a patient referred for care would entitle the surgeon to an initial new patient visit to establish records and determine surgery. After that, the office visits would not be billable. There are a few exceptions when an additional office visit may be warranted:

The E&M reason is unrelated to the primary surgical procedure.
Services are needed to stabilize the patient.
Services not usually associated with the type of surgery are required.
Unusual circumstances, complications, exacerbations or recurrences occur.
The patient complains of unrelated diseases or injuries.

In these instances, the E&M code occurring during the global period would need to have a modifier -24 (unrelated E&M service by the same physician during a postoperative period) or -25 (significant, separately identifiable E&M service by the same physician on the same day of the procedure or other service) attached to the respective E&M code.

Other Factors Impacting Reimbursement

The provider's billing office should familiarize themselves with the limitations and restrictions contained in Rule 17 (the medical treatment guidelines) and Rule 18. The rule is divided into sections corresponding to the conversion factor sections of the fee schedule listed above. These rule-generated limitations may involve time limits, level of training necessary to provide the service, limits to number of treatments (in tandem with the Treatment Guidelines), etc.

In addition, podiatrists' offices need to be familiar with the "Surgery Guidelines" as given in the surgical section of the RVP©, giving particular attention to the use of modifiers to identify bilateral procedures, multiple surgical procedures on the same day in the same operative setting, use of two surgeons, a surgical team, and assistants at surgery.

Radiology and Pathology

These sections are relatively straightforward. Always indicate how much of a radiology or pathology procedure or lab was completed by billing the appropriate modifier. The appropriate modifiers are -26 (professional), -TC (technical component) and -00 (entire procedure).

The Relative Values for Physicians© defines the professional modifier (-26), technical modifier (-TC) and total component (-00) of a radiology, pathology or laboratory procedure or test. Modifier -26 indicates that the medical professional's interpretation and written report of the procedure or test, and/or the examination of the patient, was completed. The technical component modifier (-TC) applies only to the equipment, materials, space, technical personnel, and other overhead necessary to conduct and complete the test or procedure. The total procedure modifier (-00) indicates that both the technical and professional components were completed.

Note: when reviewing a report from a radiologist or pathologist, it is inappropriate to bill the radiology code with the -26 modifier.

Medicine –Biofeedback – Manipulation - Psychology

Biofeedback

Biofeedback is limited to the number of visits recommended in the MTGs. You must have prior authorization to exceed the guidelines. Unless provided or supervised by a physician or psychologist with evidence of biofeedback training, the person providing the biofeedback shall be certified by the Biofeedback Certification Institution of America.

Manipulation

Prior authorization from the payer is necessary before billing for more than four body regions in one visit. Manipulative therapy is limited to the maximum allowed in the relevant Rule 17 medical treatment guideline.

An E&M office visit may be billed on the same day as the manipulation if the provider can document that the patient's condition required a significant and separately identifiable E&M service that is unrelated to the pre- and post-manipulation assessments. A modifier -25 must be appended to the billed E&M code when manipulation is billed on the same date of services for the same patient.

Psychology

Physicians and licensed psychologists (PsyD, PhD, EdD) are reimbursed the maximum fee schedule allowed amount or the amount billed, whichever is less. Other non-

physician providers performing psychological psychiatric services shall be paid at 75% of the fee schedule allowed amount or the amount billed, whichever is less.

Providers should review Rule 18-5(G)(6)(b) for time limitations on evaluations, testing and psychotherapy sessions, keeping in mind that with documented prior authorization of the payer these limits may be extended.

Special attention should be paid to diagnostic interview codes, as some are based on a minute basis. In such cases, an hour would require 60 in the Days/Unit column of the CMS 1500 (08-05) to be reimbursed correctly.

Physical Medicine Billing Rules

The following restrictions are found in Rule 18-5(H):

Rule 18-5(H):

(1) Prior authorization is required for medical nutrition therapy.

(3) Special Note to All Physical Medicine and Rehabilitation Providers

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

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

(4) Interdisciplinary Rehabilitation Programs – (Requires prior authorization)

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

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

(5) Unless the provider's medical records reflect medical necessity and the provider obtains prior authorization for payment from the payer to exceed the one-hour limitation, the maximum amount of time allowed is one hour of procedures per day, per discipline.

(6) Modalities:

Because many physical medicine treatments include both timed and non-timed procedures, documentation must be sufficient to substantiate the time involved. For standard visits, the documentation must indicate to the payer how the services provided were administered to stay within the one-hour limitation. While a particular procedure may not be "timed," the total time of treatment should not exceed the one-hour limitation. The only exceptions are the modalities, whether attended or unattended, time or not timed, that are limited to two per visit per discipline by Rule 18-5(H)(6).

Keep in mind that several physical medicine procedures require prior authorization from the payer **BEFORE** they are performed. Examples include: work conditioning, pain management, etc.

Evaluation and Management

Disability Counseling Definitions

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

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

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

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

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

Particular attention should be paid to the new Division created codes effective January 1, 2009. A complete list of the Division created codes can be found in the Director's Interpretive Bulletin 13, effective January 1, 2009.

(PTs, OTs and Athletic Trainers, as defined in §12-36-106 C.R.S., should be referred to Rule 18-5(H)(7) for clarification of office visit billing.)

Face-to-face or Telephonic Treating Physician or Qualified Non-physician Medical Team Conferences

A medical team conference can only be billed if all of the criteria listed in the CPT® are met.

Face-to-face or Telephonic Meeting by a Non-treating Physician with the Employer, Claim Representatives or any Attorney in order to provide a medical opinion on a specific workers' compensation case which is **not** accompanied by a specific report or written record. Bill Division Code Z601 at $65.00 per 15 minutes to the requesting party.

Face-to-face or Telephonic Meeting by a Non-treating Physician with the Employer, Claim Representatives or any Attorney in order to provide a medical opinion on a specific workers´ compensation case which **is** accompanied by a report or written record is bill as a special report [Rule 18-6(G)(4)]

Face-to-face or Telephonic Meeting by a Treating Physician with the Employer, Claim Representatives or any Attorney, with or without the injured worker. Claim representatives may include physicians or qualified medical personnel performing payer-initiated medical treatment reviews. Bill Division Code Z701 at $75.00 per 15 minutes for time attending the meeting and preparing the report. No travel time or mileage is separately payable and the fee includes the cost or the report for all parties, including the injured worker.

Patient Cancellation Rules

Rule 18-6(B) allows for the billing of appointments when the patient has not shown up. This allowance is permitted **only** when the **payer** has made the appointment. Reimbursement is one-half of the usual fee for the scheduled visit or $150.00, whichever is less, and billed with Division Code Z720 (Rule 18-6(B)(1)). Since the payer needs to be kept abreast of the patient's behavior and active involvement in his/her recuperation, the provider should notify the payer within two (2) business days when a patient does not keep an appointment (Rule 18-6(B)(2)) and agree to reschedule only if the payer sets the next appointment.

Copying Fees

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

Deposition and Testimony

A discussion of the rates, preparation time, scheduling fees and cancellation time-line rules are located in Rule 18-6(D) along with the respective Division created codes. All parties should consult and seek to abide by The Interprofessional Code prepared by the Colorado Bar Association, the Colorado Medical Society and the Denver Medical Society.

Routine Reports

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

Report Preparation

Completion of the 'Physician's Report of Workers' Compensation Injury" (WC164)

After the initial contact with the patient, the physician should complete a WC164, marking it to indicate an initial report. This report is reimbursable under Z750 in the amount of $42.00. When a patient reaches MMI and there is no permanent impairment, the physician is required to complete the WC164, closing, for which they may bill Z752 with a maximum reimbursement of $42.00 pursuant to Rule 18-6(G)(2)(b) and (e). Effective January 1, 2009, a Division created code Z753 is established to represent those cases where the initial report including closing are reported on the same date of service.

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

When the physician is requested to complete additional forms sent to them by a payer or employer that require 15 minutes or less to complete, the physician should bill the requesting party with code Z754. Reimbursement is $42.00 per completed form.

Special Reports

Special reports are any reports not otherwise addressed under Rule 16, 17 or 18, including any form, questionnaire or letter with variable content. This includes any independent medical evaluations or review (non-Division IMEs) and treating or non-treating medical reviewers or evaluators producing written reports pertaining to injured workers. Special reports also include payment for meeting, reviewing another's written record and amending or signing that record. Reimbursement for preparation of special reports or records requires prior agreement with the requesting party. Because narrative reports may have variable content, the content and total payment shall be agreed upon by the provider and the report's requester before the provider begins the report. If requested, the provider is entitled to a two hour deposit in advance in order to schedule any patient exam associated with a special report. The time line for cancellations is found in Rule 18-6(G)(4). The maximum allowable fee is $325.00 per hour billed in half-hour increments. For a written report only, use Division created code

Z755. For an IME or a report involving a patient exam use Z756. For the completion of a lengthy form use Z757. A face-to-face or telephonic meeting with a non-treating physician should be billed with Z758.

Supplies, Supplements, Herbs

Supplies are reimbursed at cost plus 20%. The use of supplements and herbs require prior authorization and agreement of the amount to be reimbursed. The provider should follow the requirements listed under Rule 16-9 to obtain the authorization necessary. References to herbs and supplements are found in Rule 18-6(O)(10) and 18-6(Q)(3)(c).

Acupuncture

Licensed Acupuncturist (LAc), or acupuncturists certified by an existing licensing board are limited to 14 sessions without prior authorization. The regulations concerning acupuncture are found in Rule 18-6(Q).

Use of an Interpreter

Rates and terms shall be negotiated with prior authorization except for emergency treatment. The billing code is Z722.

FORMS

(Please Insert the WC164 form here)

EXPEDITED HEARING

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

The form may be obtained at:

http://www.colorado.gov/dpa/oac/WordDocs/AppExpdHrg.doc

CMS-1500 (08-05)

CMS – 1500 (FEDERAL) BILLING FORM IS AVAILABLE THROUGH MULTIPLE VENDORS and AT VARIOUS WEBSITES.

PLEASE NOTE THAT A REVISED VERSION OF THE CMS 1500, the CMS 1500 (08-05) WAS INITIATED IN 2007.

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IMPAIRMENT

IMPAIRMENT

AMA Guides 3rd Revised Edition

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

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

Activities of Daily Living should be permanently affected.

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

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

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

Impairment Rating Tips

1. To receive an impairment for a spinal rating a patient with myofascial findings must first have "a minimum of six months of medically documented pain and rigidity with or without muscle spasm."

2. For extremities any permanent change in range of motion may qualify for a rating.

3. Permanent nerve damage generally qualifies for a rating.

4. The AMA Guides provides for impairment rating based on surgery in many cases.

Isolated Mental Impairment (no physical injury)

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

CODES OF ETHICS

Note: Only Sections A and B of this Code of Ethics are reproduced here. The complete Code of Ethics of the American Chiropractic Association may be found at the ACA's webpage, at www.acatoday.com/content_css.cfm?CID=719

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

AMERICAN CHIROPRACTIC ASSOCIATION CODE OF ETHICS

PREAMBLE

This Code of Ethics is based upon the fundamental principle that the ultimate end and object of the chiropractor's professional services and effort should be:

"The greatest good for the patient."

This Code of Ethics is for the guidance of the profession with respect to responsibilities to patients, the public and to fellow practitioners and for such consideration as may be given to them by state legislatures, state administrative agencies and also by state chiropractic associations to the extent that they are authorized under state law to exercise enforcement or disciplinary functions.

A. Responsibility to the Patient

A (1) Doctors of chiropractic should hold themselves ready at all times to respond to the call of those needing their professional services, although they are free to accept or reject a particular patient except in an emergency.

A (2) Doctors of chiropractic should attend their patients as often as they consider necessary to insure the well-being of their patients.

A (3) Having once undertaken to serve a patient, doctors of chiropractic should not neglect the patient. Doctors of chiropractic should take reasonable steps to protect their patients prior to withdrawing their professional services; such steps shall include: due notice to them allowing a reasonable time for obtaining professional services of others and delivering to their patients all papers and documents in compliance with A (5) of this Code of Ethics.

A (4) Doctors of chiropractic should be honest and endeavor to practice with the hightest degree of professional competency and honesty in the proper care of their patients.

A (5) Doctors of chiropractic should comply with a patient's authorization to provide records, or copies of such records, to those whom the patient designates as authorized to inspect or receive all or part of such records. A reasonable charge may be made for the cost of duplicating records.

A (6) Subject to the foregoing Section A (5), doctors of chiropractic should preserve and protect the patient's confidences and records, except as the patient directs or consents or the law requires otherwise. They should not discuss a patient's history, symptoms, diagnosis, or treatment with any third party until they have received the written consent of the patient or the patient's personal representative They should not exploit the trust and dependency of their patients.

A (7) Doctors of chiropractic owe loyalty, compassion and respect to their patients. Their clinical judgment and practice should be objective and exercised solely for the patient's benefit.

A (8) Doctors of chiropractic should recognize and respect the right of every person to free choice of chiropractors or other health care providers and to the right to change such choice at will.

A (9) Doctors of chiropractic are entitled to receive proper and reasonable compensation for their professional services commensurate with the value of the services they have rendered taking into consideration their experience, time required, reputation and the nature of the condition involved. Doctors of chiropractic should terminate a professional relationship when it becomes reasonably clear that the patient is not benefiting from it. Doctors of chiropractic should support and participate in proper activities designed to enable access to necessary chiropractic care on the part of persons unable to pay such reasonable fees.

A (10) Doctors of chiropractic should maintain the highest standards of professional and personal conduct, and should refrain from all illegal conduct.

A (11) Doctors of chiropractic should be ready to consult and seek the talents of other health care professionals when such consultation would benefit their patients or when their patients express a desire for such consultation.

A (12) Doctors of chiropractic should employ their best good faith efforts that the patient possesses enough information to enable an intelligent choice in regard to proposed chiropractic treatment. The patient should make his or her own determination on such treatment.

A (13) Doctors of chiropractic should utilize only those laboratory and X-ray procedures, and such devices or nutritional products that are in the best interest of the patient and not in conflict with state statute or administrative rulings.

B. Responsibility to the Public

B (1) Doctors of chiropractic should act as members of a learned profession dedicated to the promotion of health, the prevention of illness and the alleviation of suffering.

B (2) Doctors of chiropractic should observe and comply with all laws, decisions and regulations of state governmental agencies and cooperate with the pertinent activities and policies of associations legally authorized to regulate or assist in the regulation of the chiropractic profession.

B (3) Doctors of chiropractic should comport themselves as responsible citizens in the public affairs of their local community, state and nation in order to improve law, administrative procedures and public policies that pertain to chiropractic and the system of health care delivery. Doctors of chiropractic should stand ready to take the initiative in the proposal and development of measures to benefit the general public health and well-being, and should cooperate in the administration and enforcement of such measures and programs to the extent consistent with law.

B (4) Doctors of chiropractic may advertise but should exercise utmost care that such advertising is relevant to health awareness, is accurate, truthful, not misleading or false or deceptive, and scrupulously accurate in representing the chiropractor's professional status and area of special competence. Communications to the public should not appeal primarily to an individual's anxiety or create unjustified expectations of results. Doctors of chiropractic should conform to all applicable state laws, regulations and judicial decisions in connection with professional advertising.

B (5) Doctors of chiropractic should continually strive to improve their skill and competency by keeping abreast of current developments contained in the health and scientific literature, and by participating in continuing chiropractic educational programs and utilizing other appropriate means.

B (6) Doctors of chiropractic may testify either as experts or when their patients are involved in court cases, worker's compensation proceedings or in other similar administrative proceedings in personal injury or related cases.

B (7) The chiropractic profession should address itself to improvements in licensing procedures consistent with the development of the profession and of relevant advances in science.

B (8) Doctors of chiropractic who are public officers should not engage in activities which are, or may be reasonably perceived to be in conflict with their official duties.

B (9) Doctors of chiropractic should protect the public and reputation of the chiropractic profession by bringing to the attention of the appropriate public or private organizations the actions of chiropractors who engage in deception, fraud or dishonesty, or otherwise engage in conduct inconsistent with this Code of Ethics or relevant provisions of applicable law or regulations within their states.

AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE

Code of Ethical Conduct

This code establishes standards of professional ethical conduct with which each member of the American College of Occupational and Environmental Medicine (ACOEM) is expected to comply. These standards are intended to guide occupational and environmental medicine physicians in their relationships with the individuals they serve, employers and workers representatives, colleagues in the health professions, the public, and all levels of government including the judiciary.

Physicians should:

1. Accord the highest priority to the health and safety of individual in both the workplace and the environment.

2. Practice on a scientific basis with integrity and strive to acquire and maintain adequate knowledge and expertise upon which to render professional service.

3. Relate honestly and ethically in all professional relationships.

4. Strive to expand and disseminate medical knowledge and participate in ethical research efforts as appropriate.

5. Keep confidential all individual medical information, releasing such information only when required by law or overriding public health considerations, or to other physicians according to accepted medical practice, or to others at the request of the individual.

6. Recognize that employers may be entitled to counsel about an individual's medical work fitness, but not to diagnoses or specific details, except in compliance with laws and regulations.

7. Communicate to individuals and/or groups any significant observations and recommendations concerning their health or safety.

8. Recognize those medical impairments in oneself and others, including chemical dependency and abusive personal practices, which interfere with one's ability to follow the above principles and take appropriate measures.

Adopted October 25, 1993 by the Board of Directors of the American College of Occupational and Environmental Medicine.

Interprofessional Code

Second Edition

Drafted by

THE INTERPROFESSIONAL COMMITTEE

and

endorsed by:

Colorado Bar Association
Denver Bar Association
Colorado Medical Society

1997
current edition

Overview of the Litigation Process

There are generally two types of legal cases. Criminal cases involve a charge prosecuted by a governmental body that some individual broke a criminal law and should be punished. Civil cases involve private disputes between individuals where damages or some other remedy is requested. Administrative claims such as workers' compensation or social security claims are resolved through a form of civil proceeding conducted by an administrative body. These different types of cases involve different burdens of proof, different rules of procedure, and different roles for the expert witness.

The expert is most often asked to become involved in a civil lawsuit. The expert can come from many different professions, such as physicians, accountants, engineers, and economists.

In civil cases, the "plaintiff" is the party who brings the lawsuit and the "defendant" is the party who is being sued. Before a lawsuit is commenced, the injured party may be referred to as the "claimant." A civil action is started by filing a "pleading" called a "Complaint" with the court, which is then "served" on the defendant along with a "Summons." The defendant must then timely file a pleading called an "Answer." Depending upon the complexity of the lawsuit, other pleadings and parties may be added. The purpose of this pleadings stage is simply to determine the legal claims, defenses and other legal issues involved. The pleadings serve as a framework for later proceedings.

The parties may then conduct discovery, where each side seeks to discover the facts and evidence relevant to the legal issues involved and which tend to support or contradict a given party's position. Various discovery devices are allowed under the Rules of Civil Procedure. These include "Interrogatories" (written questions requesting information provided under oath); "Requests for Production of Documents or Things" (written requests for documentary or tangible evidence in the possession or control of the other party); "Requests for Medical Examination" (an examination by a physician or health care specialist of a party's own choosing of some physical or mental condition which has been placed "in controversy" by the opposing party); and "Depositions" (sworn testimony taken before a shorthand reporter wherein the attorneys can personally ask questions of a party or witness).

Thus, in the discovery phase, a "treating physician," i.e., one who has provided care and treatment to a party, may be asked to provide medical records, medical reports, and patient billing. Or, a company's C.P.A. may be required to provide financial records, tax returns, and client billings. Such an expert may also be asked to give a deposition. Further, a physician who has never treated a party may be asked to perform a mental or physical examination, or an accountant who has never worked for a party may be requested to review the books and records of a party and provide a report on behalf of a party to the lawsuit solely for litigation purposes and not for treatment or regular business purposes.

Much of today's litigation involves complex factual issues concerning such areas as medicine, psychiatry, engineering, economics, rehabilitation, and law. When issues are sufficiently complex that they are beyond the common knowledge or understanding of the judge or jury, "expert testimony" by "expert witnesses" may be necessary to assist the judge or jury in determining the case.

Therefore, a witness may become an "expert witness" who is called to testify as to certain facts within his or her knowledge and give "expert opinions" on certain complex factual issues. For example, a treating or examining physician may be called as an expert witness to testify concerning the examination, care, and treatment of a party and may be requested to give opinions on such issues as diagnosis, causation, prognosis, permanency, disability, need for future treatment, and reasonableness of costs of past or future treatment.

In investigating or evaluating a case involving complex factual issues, an expert may also be asked simply to assist an attorney or party in understanding the issues involved. In doing so, the expert may become an "expert consultant" or "specially retained expert." Such an individual does not thereby agree to become an "expert witness" for that party and can limit his or her review or involvement in the case simply to that of a consultant with no obligation to give expert testimony. He or she can also condition his or her involvement upon anonymity such that his or her name will not be disclosed to opposing counsel or to the court, unless compelling circumstances justify a court order requiring disclosure. If such a limited or

conditional role is requested, it should be clearly understood between the expert and the attorney, and preferably reduced to writing, to avoid future confusion or disputes.

An "expert consultant" or "specially retained expert" may agree to become an "expert witness" on the issues he or she has reviewed. These may involve complex issues of causation, or apportionment of injuries as between multiple causes, in claims involving products liability, medical liability, workers' compensation, or other personal injury actions. This may also include issues such as "standard of care," "informed consent," or other issues involving propriety of conduct or responsibility.

Sometime before trial, each party must disclose his or her "expert witnesses" to the other side and to the court. Simply because an expert is disclosed by one party or another does not suggest that the expert's opinions are expected to be totally favorable to that party or that the expert should be anything other than fair and objective to all sides. The disclosure of the experts is pursuant to the rules governing procedure in the courts where the case is filed. If the expert is disclosed past the required deadlines in the rules, the expert may not be allowed to testify.

The rules are quite specific and broad requiring the items that must be disclosed for an expert specially retained to testify and include such items as a copy of the expert's report or summary; a complete statement of all opinions to be expressed and the basis and reasons therefor; the data or other information considered by the witness in forming the opinions; any exhibits to be used as a summary or support for the opinions; the qualifications of the witness, including a list of all publications authored by the witness within the preceding ten years; the compensation for the study and testimony; and a listing of any other cases in which the witness has testified as an expert at trial or by deposition within the preceding four years.

Experts such as treating physicians are often endorsed as possible expert witnesses based solely on their role as a treating physician and the notes or records they have generated, even though they have never been contacted by the lawyer. The disclosures required for these experts are much less burdensome. Opinions or other potential testimony of an expert that are not adequately disclosed to the other side and to the court can result in their not being allowed at trial.

After an expert witness is disclosed, he or she may be asked to submit to a deposition so that the opposing attorney can gain further knowledge as to that expert's opinions and possible testimony. This also assists the opposing attorney in assessing the need for obtaining an expert of his or her own choosing to address the same issue.

If the case proceeds to trial, those experts who have been disclosed as expert witnesses may be called to testify. The party who calls the witness asks the first series of questions on "direct examination," the opposing attorney can then "cross-examine," and there may be further "redirect examination" by the attorney who called the witness. Adequate pretrial consultations should prepare the expert concerning this trial testimony.

In jury trials, the judge determines the admissibility of evidence and instructs the jury on the applicable law. The jury determines the facts based on the credibility of the witnesses and the weight of the evidence and determines the outcome based on the law as provided by the court. If legal errors were made by the court in ruling on motions, admitting evidence, or instructing the jury, a party may ask the trial court to correct that error or may appeal to an appellate court.

Most civil cases are settled. Settlement can occur at any time, including before the case is filed, during the pretrial phase or discovery phase, during trial or even jury deliberations, or after trial and during appeal.

General Principles

1.1 In cases involving personal injuries and where a patient suffers from a condition which is the subject of a legal dispute, a treating physician has a duty to provide medical information pertinent to the patient's claim in reports, depositions, conferences and trial testimony. In other cases,

experts may have a duty to provide information that experts have obtained in the course of their normal duties, such as an accountant auditing books of a business.

It is recognized that the primary duty of a physician is to treat a patient's illness or injuries. However, an additional responsibility of a treating physician is to provide necessary medical information and opinions by virtue of his or her acceptance of that patient for treatment. Like any other citizen, a physician or other expert can be required to tell what he or she knows if such information will aid the judicial process.

The transmittal of this medical or other information may include a written report which either sets forth the diagnosis, treatment and prognosis, or which responds to specific questions posed by an attorney concerning important issues in the case. Later, the expert's deposition may be taken to "discover" further information. Incidental to these contacts, one or more conferences between the expert and the attorney endorsing or retaining the expert may be requested. Finally, if the case does not settle, the expert may be called as a witness to testify in court.

The expert and attorney should cooperate in this information-gathering process to facilitate settlement, promote the administration of justice, and control the costs of litigation.

1.2 Experts and attorneys should openly communicate with one another and, wherever possible, agree in advance concerning the terms of their relationship so as to avoid conflict and disputes between the professions.

Open communication is the touchstone of dispute avoidance and dispute resolution. While experts' services are essential to the administration of justice, the expert and attorney should seek out and discuss ways of minimizing the burden of services on physicians and other experts as well as minimizing the cost to clients. Unless an attorney and expert have a history of prior business dealings, it is desirable to agree in advance concerning the nature, scope, and cost of the expert's services. (These subjects are discussed in greater detail in other sections of this Code.) The expert may already have set policies, or an agreement may be worked out at the time of the initial contact. Preferably this agreement should be reduced to writing.

If an agreement cannot be reached, the matter should be discussed immediately. At all times, the client's best interests should be the overriding concern. The professionals should agree on as much as possible and submit any residual dispute to the court or an interprofessional dispute resolution committee.

Toward this end, direct communication between the expert and attorney is preferable to communication between secretaries, receptionists, or clerical staff.

1.3 The role of the expert is not that of an advocate or trier of fact and, at all times, the expert's opinions should remain fair, unbiased, and objective.

The role of the expert in a lawsuit is that of a witness only. The expert should never become an advocate or a trier of fact. The expert should not seek to openly support or oppose the position of either party. No matter how much he or she inwardly favors or opposes the cause of one party to a lawsuit, it is the expert's clear duty to present information in a fair, unbiased, and objective fashion. When called to testify, the expert's duty is to answer the questions truthfully and to the best of his or her knowledge. Under no circumstances is an expert justified in suppressing evidence. The expert should never be influenced by extraneous matters such as the source of his or her compensation, friendships, personalities, or inappropriate pressures from patients, clients, attorneys, insurers, or professional organizations.

1.4 Although an attorney is an advocate, an attorney is never justified in abusing or intimidating an expert witness in any manner, in an attempt to discourage the expert's further involvement in the litigation or to alter or suppress the expert's testimony.

An attorney is an advocate and has a duty to zealously represent his client's best interests in litigation. However, that duty as advocate never justifies abuse, intimidation, badgering, or personal attacks on a witness. Improper attempts to discourage the expert's further involvement in the litigation or to alter or

suppress the expert's testimony should be strongly denounced. Such attempts are never justified or necessary. Adequate means are available to test credibility by cross-examination, impeachment, and rebuttal. An expert need not tolerate abusive or improper conduct and should promptly bring it to the attention of the opposing counsel, the court or tribunal in which the action is pending, or an appropriate grievance committee.

1.5 Attorneys should refrain from giving advice on medical management or interfering in the physician-patient relationship. Similarly, physicians should refrain from giving advice on legal matters or interfering in the attorney-client relationship. In other cases, non-physician experts and attorneys should refrain from interfering in the relationship between the expert, his or her client, and the attorney and client.

Physicians, other experts, and attorneys must recognize that they hold a position of trust and confidence with their patient-client. Each professional must recognize the limitations of his or her role and expertise and defer to the other professional in matters uniquely within that individual's expertise.

Hence, a lawyer should not encourage "physician shopping" or "expert shopping," should not counsel a client concerning treatment options, and should not otherwise improperly influence the client in an attempt to accentuate damages.

At the same time, the expert should refrain from counseling the client concerning such legal matters as the value of the client's claim, the nature or terms of the fee agreement with the attorney, or trial techniques and strategy decisions. These are exclusively the province of the lawyer.

Confidentiality of Information

2.1 Information obtained by experts in the course of their regular duties may be privileged by statute and deemed confidential. Such privileges exist for physicians, clergy, attorneys, accountants, licensed psychologists, and others. Great care must be exercised to prevent unauthorized or inappropriate disclosures of such confidential information.

To assure frank and complete disclosure of sensitive information concerning a person's health, legal matters, religious matters, or other privileged information and to assist a particular expert in providing services for the expert's patient or client, the law in Colorado recognizes that such information is privileged and confidential and cannot generally be disclosed without the patient or client's consent. See C.R.S. § 13-90-107.

The unauthorized disclosure of such confidential information may expose the expert to a common law claim for

damages; it may constitute a violation of the expert-patient/client privilege; it may be a breach of the expert's ethics; and may also constitute a felony under Colorado's Theft of Medical Information Statute, C.R.S. § 18-4-412.

There are restrictions regarding meeting with and/or disclosing information to the patient's adversaries. See § 6.3 for further discussion.

In certain circumstances, if the disclosure of sensitive medical, psychiatric, psychological, or other confidential information would undermine the relationship with the patient/client, or adversely affect his or her treatment or services, disclosure may be opposed until appropriately reviewed by a court. If a question arises concerning the propriety of a requested disclosure of confidential information, the expert should consult the patient/client or the patient's/client's attorney, or seek advice from the expert's personal attorney.

Medical Records

3.1 Complete and accurate medical records should be maintained for each patient.

Medical records are not only necessary for proper patient care but also assume important medico-legal implications. They are invaluable to the physician in defending medical liability claims. They are also of great assistance in evaluating and presenting a patient's personal injury claim. If they are sufficiently complete and legible, they may avoid the necessity, time, expense, and effort of formal reports. Because of their medico-legal importance, accuracy is crucial and such records must not be altered, supplemented, or destroyed because of pending or anticipated litigation.

Complete and accurate records should be maintained by other experts under various Colorado laws and rules, such as for attorneys and accountants. These records are also important in evaluating claims that may exist with regard to the services provided or for other issues. Such records should be available to the patient/client under similar conditions to medical records set forth in this Section 3.1 through 3.4.

3.2 A medical release authorization form, complying with all federal and state statutes and regulations, should be provided to the physician or health care provider before medical records are released.

By Colorado statute, patient medical records are available for inspection and copying upon " ... submission of a written authorization-request for records, dated and signed by the patient ... " C.R.S. §25-1-801.

Federal Privacy Acts concerning the release of drug and alcohol treatment program records also have very specific requirements concerning the contents of an authorization form (42 C.F.R. 2.31). Other federal, state, and local statutes, laws, and regulations may also limit the disclosure and dissemination of certain medically related information.

A standard approved authorization form, complying with all existing applicable laws and privacy interests, has been developed in a joint effort by the Colorado Bar Association Interprofessional Committee and the Colorado Certified Medical Record Administrators, and is included here as an Appendix. If questions arise concerning the propriety of releasing certain information, the health care provider should contact his or her attorney. The requirement by some institutions and health care providers that a special internally developed form be used is disapproved. Such special forms add undue expense and are a waste of time and effort to the institution or health care provider, as well as to the patient and attorney. The perceived advantages of internal forms are outweighed by the advantages of the standard approved authorization form.

Further, an internal requirement by a health care provider that the form be signed within a certain period of time prior to the request is disapproved, and the signed form should be deemed valid unless, by its expressed terms, it has expired.

There is no requirement that the signature be notarized. The release should identify the individual or entity to which the authorization is given, but one release may cover multiple health care providers. There should be a description of the information requested, and specific authorization should be stated if drug or alcohol treatment records or psychiatric or psychological records are requested.

3.3 A treating physician should surrender legible and complete copies of all records requested in the authorization to assist a patient in litigation and to advance the administration of justice.

Under Colorado law, a patient has a right of access to his or her patient records. An exception applies to certain psychiatric or psychological records which have special restrictions before disclosure is allowed. CRS §25-1-801 et seq.

A physician therefore has a duty to provide all information requested in a patient authorization concerning a patient's health to assist the parties and the finder of fact in the evaluation and presentation of that patient's personal injury claim. (See §1.1.)

Often times, all parties to a lawsuit will request such medical records. When this occurs, an attempt should be made to coordinate requests for medical records to avoid needless duplication of effort and unnecessary inconvenience to the health care provider.

Whenever possible, if a medical records deposition is taken and the only purpose is to obtain patient medical records, the subpoena should be addressed to the custodian of records or the physician's agent and not the physician.

Generally, the original medical records or x-rays should not be provided, but should be available for examination. While releasing original records or x-rays may pose some concerns, where necessary to release the originals, a receipt should be obtained. All copies provided should be complete and legible. If records are not legible, a literal transcription of those records may be requested.

If original records from a health care provider are required for trial purposes, this should be fully explained to the custodian of the records. Promptly following the completion of the trial, copies should be substituted in the court file for the original records and the originals should be returned to the custodian.

3.4 A reasonable charge may be requested for copies of medical records. However, the charge may not exceed that permitted by Colorado Department of Public Health and Environment regulations.

Currently, the Colorado Department of Public Health and Environment regulations governing patient access to medical records from licensed health institutions, facilities, or health care providers mandates that the maximum allowable charge can not exceed $14.00 for the first ten or fewer pages, $0.50 per page for pages 11-40, and $.33 per page for every additional page without Department approval. Actual postage or shipping costs and applicable sales tax, if any, also may be charged. The per-page fee for records copied from microfilm shall be $1.50 per page. No fees shall be charged by a health care provider of patient records for requests for medical records received from another health care provider or to an individual regulated pursuant to Section 25-1-802(1) solely for the purpose of providing continuing medical care to a patient. Chapter II 5.2.3.4. A physician or health care provider cannot charge an exorbitant fee for medical records simply because litigation is involved or he or she wishes to discourage litigation-related requests. (See § 9.3.)

If an attorney requests that a physician's hand-written chart be transcribed, an additional reasonable charge may be requested for that service.

Records should be released without regard to any outstanding unpaid balance due on the patient's bill for medical treatment. (See § 9.7.)

Although there are no current regulations for records kept by other experts, they should also be entitled to a reasonable charge for copying records. The reasonableness of the charge will be evaluated by reference to the standard set by the Colorado Department of Public Health and Environment.

Expert Opinions, Reports and Endorsements

In many instances, expert reports may be legally required by procedural rules or court order. Even when not required, reports from experts may foster settlement or avoid more formal, expensive, and time-consuming depositions.

Experts should be mindful that all expert opinions must be disclosed to the opposing side by way of either a report or an endorsement of the expert witness in discovery or pre-trial documents. If an opinion is not disclosed, it may be precluded. Therefore, clear communication of the expert's opinion is of utmost importance.

4.1A request for a formal expert opinion should be in writing. It should fully inform the expert concerning the purpose for which the opinion is sought. It should identify the parties to the claim and the party requesting the opinion. It should specify the information and documentation

provided to the expert on which the expert opinion should be based. The request should preferably provide a brief summary of the case. The request should specify the issues to be addressed by the expert and the legal terminology, if any, involved or required. The request should list all information that the expert will be required by court rule to disclose. The request may recite the financial arrangements to which the expert and the attorney have agreed.

The request for a formal expert opinion is intended to alleviate any future misunderstandings concerning the nature, scope, and purpose of the expert's review and further involvement. In many cases, a request for a formal expert opinion may be preceded by a conference at which the expert's qualifications will be reviewed and the issues requiring the expert's opinion described. The information needed by the expert to complete the review will also be discussed. Information about the expert that must be disclosed because of court rules will be discussed. This information may include the qualifications of the expert, the expert's publications, and any previous cases in which the expert has testified at trial or deposition within the preceding four years. Financial arrangements will be agreed upon.

4.2 The attorney has the duty to determine the expert's legal competency to render opinions on a given issue. The expert should recognize the difference between a legal expert and an expert among his or her peers in a given specialty.

The attorney should be familiar with the legal rules of evidence governing competency of expert witnesses. It is the attorney's duty to make adequate inquiry into the expert's education, background, training, and experience to determine if the expert is legally qualified to address a given issue. An attorney should accept the limitations of the expert's expertise and avoid attempts to obtain opinions from an expert that are clearly beyond that expert's expertise.

At the same time, the expert should be aware that under the Colorado and Federal Rules of Evidence, an expert witness is one who by knowledge, skill, experience, training, or education, has sufficient knowledge and expertise to assist the trier of fact to understand the evidence or determine a fact in issue. To qualify as an expert for the purpose of testifying at trial, such an individual need not be a super-specialist or a university professor, nor must that person be recognized as an expert in a given subspecialty by the expert's peer group.

However, when an expert is testifying on the issue of standard of care in a medical negligence case, he or she is required to be substantially familiar with the applicable standards of care and practice as they relate to the act or omission in issue. The expert must also be in the same subspecialty or in a subspecialty with similar standards of care and practice as the defendant health care provider to testify with respect to standard of care issues. These restrictions do not apply to other testimony, such as degree of permanency of mental or physical impairment.

4.3 A copy of all records and other documentation pertinent to the issues to be addressed by the expert should be furnished to a reviewing expert before a formal opinion is rendered.

Experts who have had direct contact with the patient-client may rely on their observations, findings, and records in rendering their opinion. For example, treating and examining physicians may legitimately rely upon the history, examination findings, radiological studies, and other test results which they acquire in their treatment or examination of a claimant.

However, non-treating physicians and experts who are retained or specially employed to independently evaluate or review an issue should be provided with all relevant documentation and records so that the opinions rendered are fully informed. The practice of providing only partial records which are favorable to a client's position is firmly condemned. If an expert requests further information which is reasonably available to the attorney, it should be provided. However, the expert should not be burdened with unnecessary, extraneous materials. Fair and unbiased summaries of depositions, records, or other facts may be provided to assist the expert in economically reviewing the issue involved.

The expert and retaining attorney should discuss the advantages and disadvantages of providing other experts' reports to the reviewing expert before he or she arrives at an opinion. Such disclosure of other

experts' opinions may appear to affect the expert's independence and objectivity in his or her initial review.

Both expert and attorney should bear in mind that all documentation and information provided to the testifying expert, as well as all research, notes, reports, and other papers generated by the expert in his or her review of the claim, are discoverable by the opposing side.

4.4 If the treating physician or expert in another field who has not been retained or specially employed to provide expert testimony has an opinion, he or she may be obligated to state it. It is unclear to what extent an expert may be required to form an opinion.

The extent to which experts may be required to formulate expert opinions is unclear. However, a physician and other expert can be compelled to state his or her observations concerning a patient or other event that he or she has witnessed and may be required to testify as to information acquired in the course of treating a patient or investigating a matter. If the expert has an opinion concerning an issue, he or she may be compelled to express it.

An expert may also be required to answer hypothetical questions. If the expert can answer the questions as posed, he or she must do so. If further facts or study are necessary to answer the questions, the expert may so state.

4.5 Expert witnesses should be advised of factual disputes concerning the underlying facts on which the expert opinion is to be based. Even though the expert is asked to assume a "hypothetical" set of facts, the expert witness should still be provided with all relevant facts and records.

Experts asked to review issues should understand that they are not the ultimate finders of facts. Therefore, there may be factual issues which are beyond the competence of an expert witness to resolve, as where there are discrepancies in various records or disagreements over certain conversations, etc. The expert may therefore be requested to assume the truthfulness of a "hypothetical" set of facts when formulating his or her opinion.

"Hypothetical" facts do involve real cases. The reviewing expert should still be provided with all relevant records and facts and is entitled to know the nature of the underlying dispute.

In responding to hypothetical questions, the expert witness should set forth the significant factual assumptions underlying his or her opinions, and may qualify an opinion by stating that it could change if different factual assumptions were made.

4.6 It is preferable that the expert's opinions be set forth in writing in the expert's own language. If an attorney makes an expert witness endorsement or summary in addition to, or in lieu of, an expert report issued by the expert, such an endorsement or summary should only be done after its contents have been carefully reviewed and approved by the expert.

Experts often prefer that their opinions be set forth in writing to avoid future misunderstanding concerning the nature, extent, and scope of the expert's review and opinions. The expert report also assures that the opinions are accurately communicated in the expert's own language.

In cases filed in the federal court, experts who are "retained or specially employed" to provide expert testimony in the case, or whose duties as an employee of a party to the case regularly involve giving testimony, must prepare and sign a written report. That report must contain a complete statement of all opinions to be expressed and the bases and reasons therefore; the data or other information considered by the witness in forming the opinions; any exhibits to be used as a summary of or support for the opinions; the qualifications of the witness, including a list of all publications authored by the witness within the preceding ten years; the compensation to be paid for the study and testimony; and a listing of any other cases in which the witness has testified as an expert at trial or by deposition within the preceding four years.

In cases filed in state courts, the expert's opinions may be set forth in either a written report prepared by the expert or a summary of the expert's opinions prepared by the lawyer. The report or summary must contain a complete statement of all opinions to be expressed and the bases and reasons therefore. With regard to "retained or specially employed" experts, the report or summary must also contain the data or other information considered by the witness in forming the opinions; any exhibits to be used as a summary of or support for the opinions; the qualifications of the witness, including a list of all publications authored by the witness within the preceding ten years; the compensation for the study and testimony; and a listing of any other cases in which the witness has testified as an expert at trial or by deposition within the preceding four years. In state court cases, if a report has been issued by the expert, it must be provided whether or not a written summary of the expert's opinions is also provided to the court.

To avoid miscommunication, expert witness reports should be encouraged. However, when an affidavit or a pre-trial summary of expert testimony is drafted by the attorney in the attorney's own language, legal terminology should be fully explained, and it should not be tendered to the court or opposing counsel until its contents are fully approved by the expert to whom the opinions are attributed.

4.7 Expert reports should be promptly provided.

Physicians and other experts should recognize that there are often legal time restrictions and court-imposed deadlines concerning the submission of expert reports or the summary of expert opinions. Therefore, attorneys should retain the expert and request reports sufficiently in advance of such deadlines so as to avoid inconvenience and hardship to the reviewing physician or expert. At the same time, undue delay in providing expert reports may hamper settlement negotiations, cause otherwise unnecessary continuances of trial dates, create burdensome scheduling difficulties for later depositions, or otherwise prejudice the party's ability to use the expert witness at trial.

4.8 An expert's report should be accurate and objective, and should fully and fairly address the issues presented. The author should be mindful of the legal terminology necessary to satisfy evidentiary rules concerning competency and burden of proof.

The expert should be aware of the significance and use of his or her reports. They play a vital role in the settlement process and in the necessary pretrial disclosure of expert witness opinions. The expert should therefore carefully review the attorney's request for the report and fully and objectively answer any special questions posed. Where legal terminology is required, the expert should attempt to set forth his or her opinions consistent with that necessary legal terminology.

4.9 Unless otherwise requested, a report from a treating physician should generally include the following information:
(a)History of present illness
(b)Examination findings
(c)Pertinent radiological and other diagnostic test results
(d)Diagnosis
(e)Etiology and/or causation
(f)Treatment rendered
(g)Course and prognosis, including anticipated permanency and residual disability
(h)Future treatment options and needs
(i)Past and future medically related expense

Reports or summaries of opinions from other experts must contain a complete statement of all opinions to be expressed by the expert at trial and the bases and reasons for those opinions.

4.10 A reasonable charge may be made for the time spent in preparing an expert's report, and payment may be requested in advance of the expert's release of the report.

Experts have the right to be reasonably compensated for preparation of reports. The amount, terms, and conditions of such payment should be handled at the outset, preferably in a written retainer agreement or a letter setting forth the expert's policies. (See § 9.2.)

4.11 The furnishing of an expert report should never be conditioned upon payment of a bill for the underlying treatment or services. (See §9.7.)

4.12 Any expert is entitled to be advised whether he or she may be the subject of a professional liability claim if the expert is contacted by an attorney representing the claimant. If the expert is so advised, he or she should not provide a new written report to the attorney without first contacting his or her professional liability insurer and/or attorney. The expert must provide the complete records, unaltered, to the requesting party.

When an expert is contacted by a claimant's attorney and advised that he or she is being investigated as a possible defendant in a professional liability claim, the expert should not provide that attorney with new summary reports concerning the claim or facts underlying the claim. The complete records unaltered must be provided to the requesting party. The expert should also contact his or her professional liability carrier and/or attorney.

Similarly, attorneys investigating a potential professional liability claim against an expert should clearly state their purpose when requesting information from the expert about the claim.

Choice of Language and the Communication of Expert Opinions and Testimony

5.1 Experts and attorneys should attempt to understand the differences between their own professional concepts and legal definitions and standards to avoid confusion in opinions.

Experts and attorneys often differ in the terms of art they use in their respective professions. For example, physicians and attorneys differ in their defining of causation. This often leads to misunderstanding when the physician is asked an expert opinion on the issue of legal causation.

Medical etiology is the science of determining the causes of disease requiring medical treatment. As such, it is concerned with all possible causes. Through differential diagnosis, these causes can be narrowed such that treatment is rendered based on a final diagnosis. Therefore, the physician focuses primarily on those causes which are still operative and can be controlled, altered, or removed by treatment such that the outcome is affected. Legal causation focuses on these earlier precipitating or aggravating causes brought about by allegedly tortious conduct. Legal causation is a political and social decision as to where society feels a loss should fall. It is a factual determination, based on legal standards, as to whether a sufficient causal relationship exists between the alleged wrongdoing and the injury complained of.

Legal causation therefore has little to do with medical etiology and focuses on the role of a single past traumatic event rather than all possible causes and conditions contributing to a medical condition.

A legal cause is often defined as a cause without which the claimed injury would not have occurred. A legal cause is also sometimes defined as conduct which is a "substantial factor" in bringing about the claimed injuries. It need not be the sole cause nor the last or nearest cause.

So long as it is a cause, it does not matter that it joined with other causes to bring about the claimed injury.

In cases where an underlying symptomatic medical condition was aggravated or worsened by a defendant's conduct, the defendant will only be responsible for that portion of the total harm caused by his or her conduct. These cases often require a physician's opinion attempting to apportion the plaintiff's underlying condition and the aggravation of that condition by defendant's conduct. If apportionment is impossible, the law will hold the defendant legally responsible for all of the harm. However, under the law there should be no apportionment made for asymptomatic pre-existing physical frailties, mental conditions, illness, etc. that may have made the plaintiff more susceptible to injury, disability or impairment.

Accountants, engineers, and court reporters may all use terms and concepts which differ from the meaning which attaches to those terms and concepts in a legal setting. Thus, experts and attorneys need to be clear on the other professional's use of various terms and concepts that may differ from their own.

5.2 An expert should understand the legal standards of proof and evidentiary rules concerning expert opinions, and attempt to express opinions by using necessary legal terminology.

Each profession has a highly technical language largely unknown to the other. This technical terminology is needed in each profession to attain accuracy and certainty of meaning. However, while this terminology facilitates understanding within a profession, it often blocks understanding between professions. Experts reporting or testifying in a lawsuit or claim should attempt to understand some of the legal standards of proof and technical terminology. The expert should understand that law is largely a profession based on words and language. Therefore, while many legal terms are foreign to the expert, they are of critical importance in stating a relevant and competent legal opinion.

Foremost among these necessary legal terms is "reasonable probability." To be competent, an expert's opinion should generally be based upon "reasonable probability." This term simply means that which is more probable than not, more likely than not, or over 50 percent probable.

This is consistent with the legal standard of proof that findings must be based upon probabilities and not possibilities. Opinions based upon surmise, speculation, or conjecture are irrelevant and inadmissible in law. However, an opinion need not be based upon scientific or medical certainty, which is a far more stringent standard than the law requires.

Therefore, experts should attempt to express their opinions using such terms as "reasonable medical probability," or "probably" or "likely." Terms such as "possible," "might," "may," "could," "guess," "maybe," and the like may, under some circumstances, render the opinion inadmissible.

Similarly, before testifying regarding a medical or professional liability claim, the expert should be thoroughly versed on such terms and issues as "standards of care," "negligence," "respectable minority," "judgment calls," etc.

It is the responsibility of the attorney requesting an expert opinion to educate the expert concerning the legal standards of proof and the significance of technical legal terminology. This can and should be done in the various meetings with the expert and any letters requesting a formal opinion.

5.3 Experts should use clear, plain and understandable language when testifying and should attempt to avoid overuse of complex terminology.

An expert may have an excellent command of the facts and the professional language of his or her specialty and may be adequately versed in the legal terminology. However, the expert must communicate his or her facts and opinions consistent with the level of sophistication of the fact-finding body hearing the case. Expert testimony may be so technically worded that its meaning is entirely lost to the jury or is so completely misunderstood that the jury arrives at a verdict that would have been different had it known the true import of the testimony.

The expert witness should remember that his or her role is essentially that of a teacher. The testimony is not intended to impress or edify, but to explain. If the testimony does not help explain and does not clarify the issues of a particular case, it has failed in the sense that it was not useful to the determination of the case.

To make expert testimony clear, an expert witness should preferably express his or her findings and opinion in medical or technical terms first. Those terms should then be translated as accurately as possible into language intelligible to the court, attorneys, and jury.

The attorney should assist the expert witness in choosing appropriate terminology and then monitor the testimony. If undue use of complex terminology is made by the expert, it is appropriate and even recommended that the attorney interrupt the testimony and obtain necessary clarification.

In complex cases, it may be appropriate to compile a glossary of terms and definitions which, with permission of opposing counsel and the court, may be provided to the jury.

Conferences and Consultations Between the Expert and Attorney

Communication with the expert is all-important to assure that necessary, competent and persuasive expert opinions are developed. This in turn facilitates settlement and the orderly presentation of evidence at trial. Therefore, conferences and open communication between the attorney and expert are encouraged so as to minimize misunderstandings over scheduling and fees, diminish the frequency and impact of surprises to both expert and lawyer, and overcome the often-present divisiveness between the professions. (See §1.2.)

6.1 It is often advisable to meet with a potential expert at the outset before the expert has reviewed the issues or rendered a report.

An attorney and expert should often confer at the very outset before opinions are formally rendered. The attorney should explore the expert's background, training, and experience to determine that expert's competence to render opinions on the issues involved. The background facts and disputed issues should be explored. The nature, scope, and availability of records and other documentation on which the expert opinion will be based should be discussed. Any special legal concepts or language needs which should be included in a report should be addressed. The attorney and expert should discuss the issues to be addressed by the expert. The information about the expert that must be disclosed because of court rules should be discussed. See § 4.9. Finally, financial arrangements, deadlines, scheduling, and availability should be fully reviewed at the initial consultation. Such conferences can often be held over the telephone, which saves the time, expense, and inconvenience of a more formal office consultation. Reasonable fees may be charged for such telephone conferences.

6.2 An attorney who expects to call an expert who has treated or who has been retained or specifically employed on behalf of the client to testify in a deposition or at trial should confer in advance with that expert.

An attorney should always meet with an expert before a trial, hearing, or deposition to place the expert at ease. Most experts have a fear of looking "foolish" in a testimonial setting and, by proper preparation of the expert, any such fears should be alleviated while, at the same time, a more effective presentation of evidence should be fostered. It is the responsibility of the attorney to schedule that conference at a mutually convenient time sufficiently in advance of the time for testimony.

Some or all of the following topics should be discussed at a pre-deposition or pre-trial consultation:
(a) The purpose for which that expert is being called as a witness, if that purpose has not previously been disclosed;
(b) The significant issues which may arise during testimony;
(c) Any potentially problematic evidentiary rules or issues;
(d) The strengths and weaknesses of the evidence concerning these issues;
(e) The theories and evidence which will probably be advanced by the opposing side and its experts;
(f) Important legal terminology as it relates to the issues;
(g) Supporting and contrary literature;
(h) Any reports, records, or literature generated by the expert or others which should be studied to prepare for testimony;
(i) Updating and reviewing the expert's qualifications and curriculum vitae and assuring his or her competency to address certain issues;
(j) The substance of the questions the attorney will probably ask of the expert, including key specific questions and hypotheticals;

(k) The scope and content of the anticipated cross-examination by the opposing side, including prior depositions, publications, reports, conflicting medical histories, fee arrangements, etc.;
(l) Scheduling and trial or deposition procedures; and
(m) Financial arrangements.

6.3 A treating physician or nurse has a duty of confidentiality concerning a patient's medical information.

A treating physician or nurse cannot meet to discuss medical information privately with a patient's adversaries without the patient's attorney's prior knowledge of the time and place of the meeting, affording the patient's attorney the opportunity to object and be present at that meeting. This assures that the physician-patient relationship of trust and confidence is not undermined and assures the propriety of any disclosure made. A physician or nurse may refuse requests from the patient's adversaries for informal interviews altogether. However, a patient or patient's attorney may not instruct a treating physician or nurse not to participate solely for the purpose of preventing the disclosure of non-privileged information.

During such informal interviews, if granted, it is improper to disclose information not relevant to the same physical or mental condition at issue in the litigation. If there is any question or dispute as to whether information remains privileged, the information should not be disclosed until the dispute is resolved by the parties or the court.

An exception may exist to the duty of confidentiality when a physician or nurse is sued by the patient as to the condition and treatment at issue in the suit.

A non-treating expert witness should not engage in private consultations with a representative of the opposing party without the knowledge of the party who retained him or her.

Scheduling and Subpoenas

7.1 The attorney should schedule an expert's testimony in depositions or at trial far enough in advance and in such a manner so as to minimize inconvenience to the expert and disruption of the expert's practice.

Scheduling of an expert's deposition or in-court testimony should be done as far in advance as possible. It is often a good practice to advise all potential witnesses of a trial date at the time the trial is first set. Vacation schedules and other potentially conflicting obligations can then be determined and resolved in advance. Specific arrangements concerning the date, time, and place of trial testimony preferably should be made more than six (6) weeks prior to the scheduled appearance.

Similarly, depositions should be scheduled at a mutually convenient time and place. Attorneys should readily agree to depositions "after hours" at the expert's office if that is the least disruptive to the expert's practice. However, if the expert's office is not large enough to accommodate the attorneys in a multiple-party case, the expert should readily agree to the deposition being held at an attorney's office, hospital, or other convenient location.

To avoid delays and unnecessary waiting at trial, the attorney should try to schedule an expert witness as the first witness in the morning or afternoon sessions. Lay witnesses may also be used as buffers to expert witnesses. It is sometimes possible to call an expert "out of order" to accommodate his or her schedule.

However, being called "out of order" may disrupt a trial, inconvenience other witnesses and interrupt the logical flow of evidence. Therefore, while the expert is entitled to some estimate of the amount of time needed for testimony, he or she should be mindful that the attorney has little control over the court's docket, the needs of other witnesses, or the opposing attorney's conduct or questioning. These may necessarily result in some delay in testimony or other inconvenience to the expert.

7.2 Experts should understand the significance of the subpoena and honor its enforcement. Likewise, an attorney should never abuse the power of the subpoena.

A subpoena is an order of court that may be issued by an attorney, compelling a witness to appear at the time and place stated in the subpoena. A subpoena duces tecum ("subpoena to produce") requires a witness to appear and produce certain things or documents. Subpoenas may be issued for deposition or trial testimony. The failure to comply with a subpoena may constitute contempt of court and subject the noncomplying witness to fine or imprisonment unless there exists "good cause" for the failure to comply such as a true medical emergency. A witness who does not comply with a subpoena takes the risk of later having to convince the court that the emergency was of sufficient gravity to constitute "good cause."

Not only professional courtesy, but the reputation of the expert and the safety of his or her patients or clients, demands that an attorney not abuse the subpoena power. Life or health must not be jeopardized so that an expert can make a timely appearance in court. On the other hand, every reasonable effort should be made by the witness to appear as scheduled, whether or not a subpoena has been issued.

While every reasonable attempt should be made to accommodate the expert, it must be understood by the expert that he or she does not always have the right to choose the time and place to give testimony. Like any other witness, an expert summoned to court by subpoena must appear at the time and place so designated. However, it must constantly be stressed that a lawyer should never abuse the use of a subpoena and should always recognize the potentially disruptive effect it could have on an expert's practice, if reasonable arrangements have not been made in advance to have the witness set aside the time.

If an expert feels that a subpoena has been improperly used, or a subpoena duces tecum's request to produce documents is overly burdensome, oppressive, or invasive of his or her privacy, the expert should contact his or her lawyer to determine what protective measures, if any, might be available.

Even though testimony is scheduled in advance, sound reasons still exist for subpoenaing an expert. The witness should understand that the issuance of a subpoena does not signify a lack of trust in the expert's agreement to appear, nor is it intended as a heavy-handed tactic to compel a recalcitrant or hostile witness. Rather, a subpoena is often necessary to protect the interests of the client seeking the testimony of the expert and to allow the attorneys and the court to better accommodate the expert's scheduling needs. Courts are often reluctant to grant continuances in the event of an emergency, take witnesses out of order, or otherwise accommodate busy experts unless they have been previously subpoenaed.

Frequently, a judge will permit the expert who has been subpoenaed to remain "on call," which means that the expert need not be personally present at all times, so long as he or she can be reached by telephone and respond promptly when needed.

When the testimony of the expert witness has been completed, counsel should immediately move the court to excuse the witness from further appearances under the subpoena.

7.3 The use of a subpoena to compel an expert's presence does not in any way affect the expert's entitlement to an expert witness fee.

If the subject of testimony arises out of an individual's role or status as an expert, he or she is entitled to an expert witness fee. (See § 9.6.) The use of a subpoena to compel a witness's presence at a deposition, hearing, or trial does not in any way affect the expert's entitlement to such an expert witness fee.

Before a subpoena is issued and served on the expert, the better practice is for the attorney to contact the expert and attempt to agree upon a reasonable expert witness fee for complying with the subpoena. At the very least, a short note by the attorney should be served with the subpoena explaining that the check for the statutory mileage and witness fee accompanying the subpoena should not be considered the expert's sole remuneration for appearing under subpoena and a further expert witness fee is justified.

If no prior agreement is reached, the expert may bill the attorney for a reasonable expert witness fee for attending pursuant to the subpoena. (See §9.) If a disagreement arises over the entitlement to such a fee, or the amount requested, that dispute may be submitted to the court or to an interprofessional dispute resolution committee. (See §10.)

7.4 Service of a subpoena should be handled in the least disruptive manner. An expert should never seek to evade service of a subpoena so as to avoid having to give testimony.

At the time the expert's testimony is scheduled, the attorney should discuss with the expert the need for service of a subpoena and the manner in which the subpoena should be served. Personal service can be disruptive to the expert's office and embarrassing to the expert. A private process server should be instructed by the attorney concerning tactful and discrete service of a subpoena.

Many experts prefer that the subpoena be sent through the mail with a "Waiver and Acceptance of Service." This can also save the client service of process costs. If this is not returned a reasonable time before trial, personal service can still be accomplished.

An expert should never seek to evade service of a subpoena so as to avoid having to testify. This is beneath the dignity of the expert, substantially increases litigation costs, obstructs the administration of justice, and can result in eventual embarrassment to the expert when service is finally accomplished.

Depositions

8.1 Depositions are an inherent part of the pre-trial discovery process. Usually, the taking of a deposition is not in lieu of court appearance and testimony.

Depositions of witnesses, including expert witnesses, are sometimes taken for "discovery" purposes. In other words, they are taken by the attorney opposing the party retaining or endorsing the expert in order to discover the expert's opinions. As such, different rules of examination, foundation, and qualifications apply to discovery depositions than to trial testimony. Therefore, a pre-trial deposition is often not admissible at trial. This is especially so if the expert is otherwise available in the jurisdiction and amenable to compulsory attendance by the service of a subpoena.

The attorney retaining or endorsing the expert naturally does not want to rely upon his opponent's questioning to present his or her evidence. The lawyer also wants to assure an orderly presentation of evidence in compliance with all rules of evidence to assure admissibility of the testimony. Further, the attorney must be allowed the flexibility of addressing new issues that first arise during trial and could not have been reasonably foreseen prior to trial. Finally, for the trier of fact to understand and evaluate expert testimony, especially complex or conflicting testimony, it is essential that they see that testimony live and that the expert appear in court.

Under new, limited discovery rules, and new rules mandating certain advance reports and disclosures, the prior practice of routinely deposing experts may be curtailed.

8.2 The party taking the deposition is responsible for timely payment of all reasonable charges for time spent by the expert traveling to and from the deposition and for participating in the deposition, unless there is an agreement or order to the contrary. The party retaining or endorsing the expert is responsible for the cost of the expert's time in preparing for the deposition. In the event a request for review of the deposition has been made, if the witness is a treating physician, the party noticing the deposition is responsible for any reasonable cost associated with the review and signature. If the witness is a retained expert, the party retaining the expert is responsible for any reasonable cost associated with the review and signature.

The party taking the deposition must pay reasonable compensation for the deposition he or she has requested. This includes reasonable costs and fees associated with any travel to or from the deposition as well as an expert witness fee for participating in the deposition. Preparation for the deposition, on the other hand, inures primarily to the benefit of the party retaining or endorsing the expert, and that party should be responsible for that preparation time. Presumably, such preparation furthers the cause of the

endorsing party. Also, it would be unworkable and inappropriate for the opposing party to exercise control over the amount of time the other party's expert is to spend in preparation for a deposition. Rather, the party retaining or endorsing the medical expert can and should discuss and agree with the expert concerning the amount of time to be spent in preparation for a deposition and the charges to be incurred.

However, special requests made by opposing counsel for research or compiling of information may fall outside of "preparation for deposition." Who is responsible for payment of the fees for fulfilling these requests should be determined between the parties before the task is performed by the expert.

Under new rules, effective in 1995, review and signature of a deposition transcript are waived, unless the deponent or a party requests review and signature before completion of the deposition.

In the event a request for review of the deposition has been made, if the witness is a treating physician, the party noticing the deposition is responsible for any reasonable cost associated with the review and signature. If the witness is a retained expert, the party retaining the expert is responsible for any reasonable cost associated with the review and signature.

8.3 Depositions costs and fees should be reasonable and should be agreed upon in advance of the deposition. Disputes should be noted at the outset, and attempts should be made to amicably resolve such disputes or timely submit them to the court for resolution.

Deposition costs and expert witness fees should be reasonably based on the factors set forth in Section 9.2 of this code. Every effort should be made by the expert and retaining and deposing counsel prior to the deposition to agree on the manner, timing, and amount of compensation. In the alternative, the party endorsing the expert may legitimately condition the deposition upon prior financial arrangements being agreed to or determined by the court as set forth in Rule 26(b)(4) of the Colorado or Federal Rules of Civil Procedure.

An attorney taking the deposition of an opponent's expert witness should not withhold or delay payment of that expert's fees or engage in unnecessary conflict so as to discourage that expert witness from further involvement in the case, or as a means of "punishing" that expert for his or her testimony. When an agreement has not been reached and a dispute does arise, it should be promptly submitted to a judge or interprofessional committee for resolution. Any undisputed amounts should be remitted without delay.

Expert Compensation and Expert Witness Fees

9.1 Experts and attorneys should strive to agree in advance concerning the nature and scope of the services to be performed, the terms and amounts of compensation to be paid for those services, and the responsibility for payment of that compensation. Absent an agreement, disputes may arise which will require resolution by the court or an interprofessional committee.

The expert is entitled to reasonable compensation for providing services in connection with litigation. The issues of fees, costs, and scope of employment for expert services are frequent areas of disagreement. This is usually due to lack of open communication and the absence of a prior agreement between the expert and the attorney.

Therefore, whenever possible, these issues should be clarified before services are rendered and, whenever possible, confirmed by written agreement. It should be remembered that "an agreement" is not created by simply sending out a fee schedule, but is a product of negotiation and mutual consent. Failure by an attorney to object to a written fee policy may be an implied consent to abide by its terms. The agreement should be tailored to fit the specific circumstances, but it is suggested that the following be included:
(1) The scope of services to be performed by the expert;
(2) The rate of compensation to be paid for the expert's services, including whether the fee will vary depending upon the services rendered, e.g., research, review of documents, examination, dictating of report, travel, or testimony;
(3) Whether advance payments or retainers are required and, if so, under what circumstances;
(4) The handling of costs and expenses;

(5) Cancellation terms and amounts; and
(6) The person or persons responsible for payment of those costs and fees.

Experts are encouraged to develop office policies concerning involvement in legal matters, which can then be reduced to writing and provided to the attorney at the time of the initial request.

An attorney provided with such a written policy should immediately assent or object to the terms provided. It is improper for the attorney who does not object to continue to request the expert's services after being advised of the expert's policies for involvement in legal matters and then later deny that he or she agreed to the terms of those policies. However, the expert should recognize that providing the attorney with the expert's policies merely constitutes an offer and does not bind the attorney or client until they expressly or impliedly agree to those terms.

If no agreement can be reached between an expert and an attorney, the expert must recognize that he or she can still be compelled to provide necessary information and a court or Interprofessional Committee may be called upon to determine the amount and terms of reasonable compensation. A non-treating or consulting expert can simply refuse to participate absent an agreement with the attorney or his or her client.

9.2 An expert is entitled to fair and reasonable compensation for providing expert testimony.

In determining what constitutes a fair and reasonable expert witness fee, some or all of the following factors should be considered:[1]

(1) The amount of time spent, including review, preparation, drafting reports, travel, or testimony;
(2) The degree of knowledge, learning, or skill required;
(3) The amount of effort expended;
(4) The uniqueness of the expert's qualifications;
(5) Current and reliable statistical income information of similarly situated experts;
(6) The amounts charged by similarly situated experts for similar services;
(7) The amount of other professional fees lost; and
(8) The impact, if any, on the expert's practice because of scheduling difficulties, other commitments, or other problems.

An expert should also be aware that some statutes, such as those governing workers' compensation claims, set reasonable medical fee schedules and provide that it is unlawful, void, and unenforceable as a debt for any health care provider to charge a claimant in excess of the scheduled fee. See C.R.S. §8-42-101(3).

The use of itemized billing by the expert to the attorney should be encouraged and will often expedite payment.

9.3 An expert is never justified in charging excessive fees so as to capitalize on the client or patient's legal problem, or so as to discourage requests for information. At the same time, an expert cannot be expected to lose money or suffer financially as a result of participation in the litigation process. The expert should recognize that it is the patient or client who is ultimately responsible for payment of such litigation costs, regardless of the outcome of the case. Hence, charges for an expert's services should generally be no higher than the expert's hourly charges for other professional services.

An expert should neither gain nor lose financially as a result of his or her participation in the litigation process. An attorney should never expect the expert to sacrifice income merely because his or her patient or client is involved in litigation. The attorney should not abuse the power of the subpoena to attempt to obtain free or discounted expert testimony.

On the other hand, expert witness fees should not be so high that the fees prevent the patient or client from obtaining the expert's services, or as to create the appearance that the expert is attempting to

capitalize on the patient's or client's legal problem. Experts should not seek to punish or deter attorneys, patients or clients from seeking the medical expert's services or information. This merely further victimizes the party who is compelled to seek compensation through litigation. The practice of charging fees in excess of those usually charged for other professional services to compensate for the "aggravation of litigation" is discouraged.

Even though the attorney may become obligated initially to pay the expert witness fees, the expert should always be mindful that the attorney's client is ultimately responsible for such litigation costs, regardless of the outcome of the case. Even in cases handled on a contingency fee basis, only the fee is contingent. While an attorney may advance these costs on behalf of the client, the lawyer's professional ethics require that the client remain ultimately responsible.

Therefore, fees charged for litigation-related services should be roughly equivalent to fees charged in the expert's practice for professional services.

9.4 In contracting for the professional services of an expert, the attorney is acting as an agent for the client. It is the client who remains ultimately responsible for such fees and costs. However, an attorney may ethically obligate himself or herself to pay the expert's fees and costs and, customarily, the attorney contacting or retaining an expert on behalf of a client is personally obligated to see that the expert is paid for litigation-related services.

An attorney is only an agent for his or her client, and litigation costs and expert witness fees are contracted for by the attorney on behalf of the client. Under agency law, an agent is usually not responsible for debts contracted for or on behalf of a disclosed principal.

However, different rules apply to expert witnesses in the litigation setting. An attorney is ethically obligated to compensate the expert directly for professional services he or she has requested. The attorney may also ethically advance or guarantee such litigation costs and expert witness fees, so long as the client remains ultimately responsible for payment.

Customarily, the attorney advances fees for expert witnesses he or she contacts on behalf of the client, even if the attorney is not obligated to do so. This is because the attorney is in a better position to assess the client's ability to pay and to collect such advanced costs from the client.

The attorney's obligation, however, is generally limited to those fees relating to the expert's services as a witness, and does not extend to payment for treatment or services rendered directly to the client or patient.

9.5Compensation of an expert witness may never be contingent upon the outcome or the content of the expert's testimony, or the court's acceptance of the witness as an expert witness.

An expert's compensation should never be conditioned upon, or measured by, the amount of the recovery in damages in the litigation. Any contingent witness fee naturally compromises the integrity of the testimony of that witness. The expert is entitled to reasonable compensation regardless of the outcome of the case.

It goes without saying that the attorney cannot condition compensation upon the content of the expert's testimony and thereby seek to purchase favorable testimony. This is clearly improper conduct on the part of the attorney.

Because the attorney should be familiar with court rules governing competency of expert testimony and has a duty to inquire concerning the qualifications of his or her tendered expert, it is also inappropriate to condition the expert's compensation upon the court's acceptance of the witness as an expert.

9.6 An expert witness fee is owed if the subject of the testimony arises out of the individual's role or status as an expert and cannot be conditioned upon the eliciting of expert "opinions."

The premise that an expert witness fee is due only if an expert opinion is elicited from the witness is not a valid assumption. An expert who comes into possession of facts or information solely because of his or her position as a professional person is entitled to receive compensation as an expert when he or she testifies to those facts in a deposition or in court. The expert's position and status at the time he or she comes into possession of relevant information determines whether the expert should be entitled to an expert witness fee.

However, the federal courts have held, in Colorado and elsewhere, that treating physicians may not be considered expert witnesses, unless specifically designated as such and unless expert opinions are elicited. The issue of whether a treating physician is an "expert" has been alluded to in a recent state court case, but not resolved.

9.7 An expert has a duty to provide information and participate in the client or patient's litigation regardless of the status of the client's or patient's bill for non-litigation related professional services.

Fees for non-litigation related professional services incurred by the party are exclusively the responsibility of the client/patient. It is unethical for the attorney to advance these costs on behalf of the party.

An expert may not condition his or her involvement in litigation (i.e., providing records, reports, depositions, or trial testimony) upon payment of the client's/patient's bill for other professional services. An expert should never feel that he or she has some financial interest in the outcome of the case, due to an unpaid bill, which might appear to taint the objectivity of expert testimony. The expert should recognize that some clients or patients are dependent upon a legal recovery to pay for past and future services. Further, public policy mandates that the expert provide necessary information and testimony to evaluate claims. However, as a professional courtesy, the attorney may make reasonable and ethical efforts to assist the expert in obtaining payment for his or her services. The attorney may urge the client to pay the expert for the services received as soon as possible regardless of the status of the lawsuit. It is not proper for the attorney to advise the client that payment for care and treatment professional services may justifiably be withheld until the lawsuit is completed. If the client has resources to make full or partial payment, the lawyer may properly urge the client to make payments due to the expert for services.

The attorney may also request permission from the client to pay the expert for such services directly out of any recovery received in the litigation. This authorization for direct disbursements to the expert can often be set forth in the attorney-client fee agreement.

9.8 Terms concerning cancellation of testimony should be discussed and agreed upon in advance. An expert is entitled to prompt notification of cancellation of testimony. Cancellation fees should be reasonably related to the actual loss to the expert.

Cancellation of testimony is often a source of interprofessional disputes. This usually can be alleviated by prior agreement between the expert and the attorney endorsing or retaining the expert. If the expert has a reasonable cancellation policy, the opposing attorney should be advised of that policy at the time a deposition is scheduled. The opposing attorney is then subject to the terms of the cancellation policy should he or she later be responsible for the cancellation of the deposition.

If a case is settled or continued, or the expert's testimony is otherwise canceled, the attorney who scheduled that testimony should immediately notify the expert of the cancellation. This should preferably be initially done by telephone and followed by a confirming letter or facsimile transmission.

In the event of settlement, the cancellation notification should also include an inquiry concerning any outstanding fees and costs which may be withheld and paid out of the settlement. As a professional courtesy, it is often a good practice to advise the expert of the outcome of the case and the role, if any, the expert played in that resolution or recovery.

Cancellation policies should be reasonable under the circumstances. There should be agreement concerning what constitutes "reasonable notice" of cancellation such that a cancellation fee will not be

charged. Two or three business days in advance is usually considered to be reasonable. Longer cancellation periods are considered on a case-by-case basis.

Cancellation fees that are charged must be reasonably related to the actual loss to the expert in terms of lost professional fees and the impact on his or her practice. If the expert can use the canceled time productively, e.g., for seeing other patients or clients, necessary administrative functions, billing, dictation of reports, reviewing professional literature, this factor should be heavily considered in determining the need for and amount of a cancellation fee. Cancellation fees that provide excessive compensation must in fairness be reduced notwithstanding any written agreement or policy.

Dispute Resolution

10.1 Interprofessional disputes should be promptly submitted to an interprofessional dispute committee. Disputants should cooperate in the submission, investigation, and resolution of such disputes.

Regardless of the best efforts of both professions to avoid disagreements, disputes do arise. The Colorado/Denver Bar Association Interprofessional Committee is available to assist with the resolution of such disputes between experts and attorneys. Other local professional societies may have similar committees. If a dispute arises, the disputants are encouraged to submit the controversy to the appropriate dispute resolution committee for review.

In matters submitted to the CBA/DBA committee, the disputants are requested to submit written summaries of relevant facts along with pertinent documentation concerning the matter in controversy. Submission of the dispute should be done with fairness and candor, without rancor, and without unprofessional remarks or other conduct which would be further divisive to interprofessional relations.

A member or members of the committee are then assigned to investigate the dispute and make recommendations for its resolution. The disputants should remember that these investigators are unpaid volunteers, and every effort should be made to cooperate in their investigation.

A final recommendation by the investigator is then reviewed by the full committee. When the committee makes a final recommendation, the disputants will be advised in writing by the interprofessional committee involved. The recommendation of the interprofessional committee is not binding unless agreed to by the disputants. However, in most cases, the recommendations of the committee are followed.

Disputes may be submitted to the following CBA/DBA committee in writing, addressed to:

Colorado Bar Association/Denver Bar Association
Interprofessional Committee
1900 Grant Street, Suite 950
Denver, Colorado 80203-4309

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[1]While not controlling or meant to suggest the parameters of acceptable fees charged by experts, the following cases are illustrative of how various judges in various jurisdictions at various times have addressed the issues surrounding reasonableness of expert witness fees:

Leadville Water Co. v. Parkville Water District, 436 P.2d 659 (Colo. 1968): Expert witness fees are subject to the trial court's discretion; unusual compensation paid by a party may not be recoverable. Amounts allowed in the case included travel, ordinary witness fees, food and lodging expenses, preparation time, and $100.00 per day for each day's attendance at trial.

Perkins v. Flatiron Structures Co., 849 P.2d 832 (Colo. App. 1992). Fees for experts' assistants are not recoverable; nor are fees for pre-trial preparation to render opinions not admitted into evidence; mileage costs are limited to statutory amounts.

American Water Dev. v. City of Alamosa, 874 P.2d 352 (Colo. App. 1994). The amount of expert witness fees is discretionary; the court may consider preparation time as well as time in court; travel, ordinary witness fees, food, and lodging may be considered.

Anthony v. Abbott Laboratory, 54 USLW 2024, D. RI 1985). $420.00 per hour fee was reduced to $250.00 for doctor associated with a medical school.

Crawford Fitting Co. v. J.T. Gibbons, Inc., 482 US 437, 107 S.Ct. 2494, 96 L.Ed. 2d 385 (1987). Federal courts can tax expert witness fees above $30.00 per day, only if expert is court-appointed.

Baldwin v. Commercial Union Ins. Co., 87 CV 26030, Denver District Court (J. Stephen Phillips, J.) $500.00 per hour fee is excessive. Fee for deposition of $125.00 per hour is set as a reasonable fee.

CAUSALITY CHART

CAUSALITY CHART

STEPS IN CAUSALITY DETERMINATION	
1.	**Establish diagnosis (or differential diagnosis if further testing required)**
2.	**Define Injury or Exposure** For Exposures include ❖ Length of exposure ❖ Level of exposure (actual lifting required, amount of repetitive motion, special tool use, etc.) ❖ Comparison of workers' exposure to that of the normal population
3.	**Discuss Intervening Factors** Concurrent non-work-related injuries or disease processes, pre-existing impairment, or disease related activities outside of work, sports, hobbies, etc.
4.	**Explain any scientific evidence supporting a cause and effect relationship between the diagnosis and the exposure or injury**
5.	**Assign a medical probability level to the case in question** ❖ Medically probable >50% likely ❖ Medically possible ≤ 50 likely

Summary Of NIOSH Reviews*

Table 1. Evidence for casual relationship between physical work factors and MSDs

Body part ***Risk factor***	**Strong Evidence (+++)**	**Evidence (++)**	**Insufficient evidence (+/0)**	**Evidence of no effect (-)**
Neck and Neck/Shoulder				
Repetition		X		
Force		X		
Posture	X			
Vibration			X	
Shoulder				
Posture		X		
Force			X	
Repetition		X		
Vibration			X	
Elbow				
Repetition			X	
Force		X		
Posture			X	
Combination	X			
Hand/wrist				
Carpal tunnel syndrome				
Repetition		X		
Force		X		
Posture			X	
Vibration		X		
Combination	X			
Tendinitis				
Repetition		X		
Force		X		
Posture		X		
Combination	X			
Hand-arm vibration syndrome				
Vibration	X			
Back				
Lifting/forceful movement	X			
Awkward posture		X		
Heavy physical work		X		
Whole body vibration	X			
Static work posture			X	

***Musculoskeletal Disorders And Workplace Factors A Critical Review of Epidemiologic Evidence for Work-Related Musculoskeletal Disorders of the Neck, Upper Extremity, and Low Back Edited by: Bruce P. Bernard, M.D., M.P.H.; U.S. Department Of Health And Human Services; Public Health Service Centers for Disease Control and Prevention National Institute for Occupational Safety and Health, July 1997**

QUALITY
WORKERS' COMP REPORTING

ELEMENTS OF A QUALITY WORKERS' COMPENSATION REPORT

1. **Identify patient and referral sources;** e.g., employer referred for first time evaluation, patient referred self without contacting employer, referred by an authorized treating physician.

2. **Specify any additional sources of information reviewed;** e.g., employer job description, x-ray or lab tests, and other medical records.

3. **Record patient's history**
   - Chief complaint
   - Details of accident or exposure
   - Occupation and job duties
   - Current functional status (work related and activities of daily living)
   - Pre-existing injuries, disease and functional status

4. **Record physical exam** - Pertinent negatives are important so be sure to examine related body regions based on mechanism of injury.

5. **Describe behavioral exam when appropriate** - Always assess for signs of depression in patients with chronic pain or delayed recovery.

6. **Note any diagnostic tests** ordered and their results if known.

7. **List diagnoses** – Be specific and use ICD-9 classification. Cumulative trauma or repetitive motion is not a diagnosis!

8. **Discuss work relatedness for each diagnosis.** State your opinion as to the medical probability (greater than 50%) that the diagnosis was caused by a work accident or job duties.

9. **Describe treatment plan -** Include expected functional goals, specific length of treatment and frequency. If treatment is outside of the Colorado Medical Treatment Guidelines justify the necessity for treatment with specific functional goals.

10. **Provide detailed work and activity restrictions.** Factors to consider:
    - Posture - sitting, standing, kneeling, etc.
    - Lifting - specify waist level, overhead, repetitive
    - Repetitive movements – keyboarding, writing, pinching, tool use
    - Hot or cold environments
    - Special tasks - driving, climbing ladders, assembly line work

11. **Describe patient education provided.** Examples:
    - Self management – e.g. application of heat or cold
    - Exercises
    - Detailed explanation of activity limitation and progression
    - Natural course of condition and expected outcome.
12. **Record expected date of next visit and any specific referrals made.**

MENTAL IMPAIRMENT

Most Examples of Psychological Screening tools that are used in this section are not available electronically. If you would like to have copies, please contact the Division's Physicians' Accreditation Program, 303-318-8763.

* *

The ZUNG SELF-RATING DEPRESSION SCALE can be found at the following webpage:

http://healthnet.umassmed.edu/mhealth/ZungSelfRatedDepressionScale.pdf

* **

The Pain Drawing can be found at:

http://www.coworkforce.com/dwc/Medical/MTGDeskReferences/pain%20diagram.pdf

COMMON MEDICAL PAYMENT ISSUES

MOST COMMON TIMELY MEDICAL PAYMENT ISSUES
Workers' Compensation Health Billing Payment and Dispute Resolution Process
Effective January 1, 2008

	ISSUE	PROCESS	APPLICABLE RULE/DOWC COMMENT
Communication		**PRIOR AUTHORIZATION OF SERVICES**	
	Prior authorization	When requesting prior authorization, providers must explain the medical necessity of the service and submit supporting documentation. The request must be as specific as possible.	Rule 16-9(E)
	Lack of authorization from adjuster	All authorization given to a provider should be specific, in writing, and internally routed to the bill reviewer and all other parties for proper handling of bill.	Rule 16-9(G), Division's recommendation
	Denial of authorization	All denials of prior authorization must be in complete compliance with Rule 16-10	Rule 16-10(E) - allows for automatic authorization if denial is not done timely. Rule 16-10(F): Unreasonable denial may lead to penalties.
		PRIOR TO SUBMITTING BILLS	
	Incomplete or inaccurate bills	Before sending the bill, the provider should verify the billed information on the CMS 1500 to insure the fields are properly filled out and the information is correct.	
	Time Line for Billing	The provider must bill within 120 days of the date of service	Rule 16-11(A)(1)
	Provider tax info not available or wrong	Providers should verify the tax ID number	
	Provider specialty not identified on bill	Bill for only one provider per CMS 1500 (08-05) form. Block 31 of the CMS 1500 (08-05) may be used to identify the supervising provider, and block 19 used to identify the provider rendering the treatment, if different than the supervising provider.	
	Provider's submission of notes and supporting documentation	The Division recommends submitting all billing documentation at the time of submitting the bill unless a private agreement exists between parties.	See Rule 16-7(E), Required Billing Forms and Accompanying Documentation, for rules concerning the submission of initial, interim and closing medical reports using division form WC164.

Hospitals are charging for copies of records	The payers request for records from the hospital needs to be specific. Ex.: A physician's billed ER visit only requires the physician's ER Room note, not the entire hospital chart, to evaluate the services billed.	Rule 16-7(E)(5)e
Provider PPO discounts taken w/o a signed contract or the contract agreement has expired.	Payers need to verify payment reductions are in compliance with PPO contracts.	Rule 16-11(D)(2)
	REVIEW AND PROCESSING OF BILLS	
No acknowledgment of receipt of bill	Within thirty days of receipt of a bill, payer should notify the billing provider, either by EOB or letter, of all bills received, even if the claim has not been established, the bill has been submitted to the wrong insurer, or the services billed are non-work related.	Rule 16-11(A)(2) and Division recommendation
Unestablished Claims – "First Report of Injury" has not been filed in a timely manner or the medical services billed are non-work related.	In cases of unestablished claims (no "First Report of Injury"), the provider should inform the patient of the need to file a claim with DOWC.	C.R.S. 8-42-101(4) Worker may use form WC15, "Worker's Claim for Compensation," available on the Division's webpage www.coworkforce.com/DWC/
Second request for medical records	Payer internal documentation routing should not necessitate a second request for documentation and/or a bill going unpaid.	Any second request for medical records by the payer should generate a copying fee billed by the provider and paid by the payer. (Rule 18-6(G)(1))
	The payer verifies all billed codes/modifiers, policy number, etc. and issues a reimbursement check and an explanation of benefits (EOB) within 30 days from receipt of bill.	Rule 16-11(A)
Down-coding or changing of codes	Payers must pay for the services as billed or deny the codes/modifiers not supported by the presented documentation and/or Relative Values for Physicians/DOWC rules. Payers are required to be very clear and specific on why they are denying the billed codes. Payers cannot change billed codes, unless the provider agrees. The provider has 60 days to resubmit the denied codes and modifiers with additional information.	Rule 16-11(B) and (C) Rule 16-11(B)(4)
	The provider should contact the payer if no check or EOB is received within 30 days to verify receipt of bills and to cross-verify accuracy of the bill.	.

	PAYMENT OR DENIAL OF PAYMENT RECEIVED	
Re-review of claims	The provider has 60 days to contest reasons for non-payment and present their argument	Rule 16-11(D)(1)
	Payer has thirty days from receipt of resubmission to pay or explain continued denial.	Rule 16-11(D)(1)
Retro-active Audits	Recovery of overpayments to providers must be within 12 months after the date of the original explanation of benefits.	Rule 16-11(E)
	DISPUTE RESOLUTION	
Disputes	In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.	Rule 16-11(D)(3) & (4)
	Unresolved disputes may follow the procedures in Rule 9.	