Legislative Reform

A 15 -Year Retrospective
July 1, 1991 - July 1, 2006

The Colorado Department
of Labor & Employment
Division of Workers' Compensation

633 17th Street, Suite 400
Denver, CO 80202

Legislative Declaration

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

C.R.S. 8-40-102 (1)

Message from the Director

Greetings. To the Colorado citizenry, reform of the workers' compensation system in 1991 was not an event of historical proportions. It did, however, result in a major impact to business and labor in this state. In recognition of the 15 year anniversary of the reform, we thought it would be interesting to publish this retrospective.

This booklet is dedicated to the previous directors who guided the Division from its formation to the present. Since its inception, the Division has been made up of many hard-working and dedicated employees. In addition, the importance and value of all those individuals and groups that have assisted the Division over the years cannot be overstated. Many people have volunteered their time and expertise to help the Division and the system, and for this we offer our sincere gratitude.

I hope you find the information in this booklet both interesting and informative.

Bob Summers, Director
Division of Workers' Compensation

Denver Public Library, Western History Collection, Creator William Henry Jackson, Call Number WHJ-561

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Denver Public Library, Western History Collection, Creator Louis Charles McClure, Call Number MCC-1847

Introduction

A Historical Perspective

Workers' compensation is the oldest form of no-fault insurance. Before workers' compensation law was established, there was little recourse for workers injured on the job. A worker could sue in court, but had to prove negligence. The outcome was uncertain and could take years to resolve. This was costly both to the employer and the worker, often with little benefit to either party. The evolutionary move toward workers' compensation began during the Industrial Revolution as mechanization brought an increase in work-related injuries. It was a new legal concept, liability without regard to fault. First established in Germany in 1856 and adopted soon after by England and most of Western Europe, workers' compensation was enacted in Colorado in 1915. By 1920, all but eight states had workers' compensation laws. The last state mandated workers' compensation coverage in 1947.

Workers' Compensation Reform

Costs were escalating and interim attempts at fixing specific cost drivers did not fully address problems endemic to a system that had become costly, unwieldy, and litigious.

The workers' compensation system, as established by the Colorado General Assembly in 1915, was intended by its creators to be an administrative system. In the 60 or so years that followed, benefits were modified to mirror the increase in wages in the community, but the original language and intent of the statute remained amazingly intact. In the mid-seventies, vocational rehabilitation became a benefit for qualified individuals who were unable to return to pre-injury employment or wages. Benefits awarded for physical impairments were expanded to include awards for loss of access to the labor market. And the question of mental stress as a compensatory illness was debated in courts across the nation. Medical and vocational experts from both sides were brought in to testify to the merits of a position and system costs skyrocketed as litigation increased. Administrative hearing systems and courts became backlogged with cases resulting in significant delays in dispute resolution. Employers experienced yearly rate increases in the double-digits for their workers' compensation premiums.

The driving factors behind the reform legislation of 1991 were present to greater or lesser degree in state systems nation-wide. Workers' compensation costs were escalating and interim attempts at fixing specific cost drivers did not fully address problems endemic to a system that had become costly, unwieldy, and litigious. The resultant premium impact and cost of doing business became a factor in the state's ability to attract new and maintain existing business.

In part, the system administrator lacked the requisite resources and powers attendant to define, correct and enforce positive, cost containment behaviors. As such, formulation of public policy relied heavily upon court interpretation.

Prior to July 1, 1991, the system was administered by the Division of Labor, a division of the Department of Labor and Employment. During the 1991 legislative session--a session devoted almost entirely to workers' compensation reform--Senate Bill 218

(SB91-218) was passed. This was a comprehensive bill that created programs and modified benefits in an attempt to control rising costs and premiums. The intent of the bill was to implement a more administratively efficient system with less litigation. The Division of Workers' Compensation was created to administer the system and its Director afforded the requisite powers to enforce compliance.

How it Works

The workers' compensation system in Colorado as administered by the Division of Workers' Compensation, is under the Department of Labor and Employment. Responsibilities of the Division Director include administration and enforcement of the workers' compensation statute, claims processing, records maintenance, insurance compliance, cost containment and first-level dispute resolution.

The Office of Administrative Courts in the Department of Personnel and Administration is responsible for fact-finding hearings and the Division of Workers' Compensation is responsible for prehearings and settlement conferences. Cases may be appealed to the Industrial Claim Appeals Panel, to the Colorado Court of Appeals and by writ of certiorari to the Colorado Supreme Court.

This insurance pays for all reasonable and necessary medical expenses related to the injury and partial wage replacement while the worker recovers from the effects of the injury or occupational disease.

In Colorado, employers are required to have workers' compensation insurance. There are some exceptions for specifically excluded occupations, individuals and certain independent contractors. Employers receive insurance coverage through insurance carriers or, if qualified, through self-insurance programs.

Workers' compensation insurance pays for all reasonable and necessary medical expenses related to the injury and partial wage replacement while the worker recovers from the effects of the injury or occupational disease. The employer initially has the right to designate the treating physician. However, the physician may be changed by mutual agreement or by order after a hearing before an administrative law judge.

If the injured worker loses more than three shifts or days of work due to the injury, the worker is eligible to receive wage loss benefits. The first three shifts or days of lost work are compensated if the disability lasts longer than two weeks. These benefits are based on two-thirds of the average weekly wage of the worker, up to a maximum amount set by statute. This compensation is called Temporary Total Disability (TTD). The maximum compensation rate is set by the Division every July based on 91% of the state average weekly wage. If the worker can return to part-time or modified work during the disability, compensation benefits are calculated at two-thirds of the difference between the worker's pre-injury average weekly wage and the worker's current earnings. These are called Temporary Partial Disability benefits (TPD). Benefits can be reduced for willful safety violations by the worker. All temporary benefits terminate when the worker is released to return or returns, to regular employment, or reaches "Maximum Medical Improvement" (MMI), which means that the injury or disease causing the disability has become stable and no further medical treatment will improve the condition.

An injured worker is eligible to receive Permanent Partial Disability (PPD) benefits if the worker sustains permanent impairment as determined by the authorized treating physician and rated in accordance with the *AMA Guides to Permanent Impairment, Third Edition, Revised.* The PPD award will either be calculated in accordance with a schedule for loss of function affecting certain body parts, such as arms, legs, vision and deafness, or as a whole person for those functional losses that are not included in the schedule, such as spine, lungs and mental impairment.

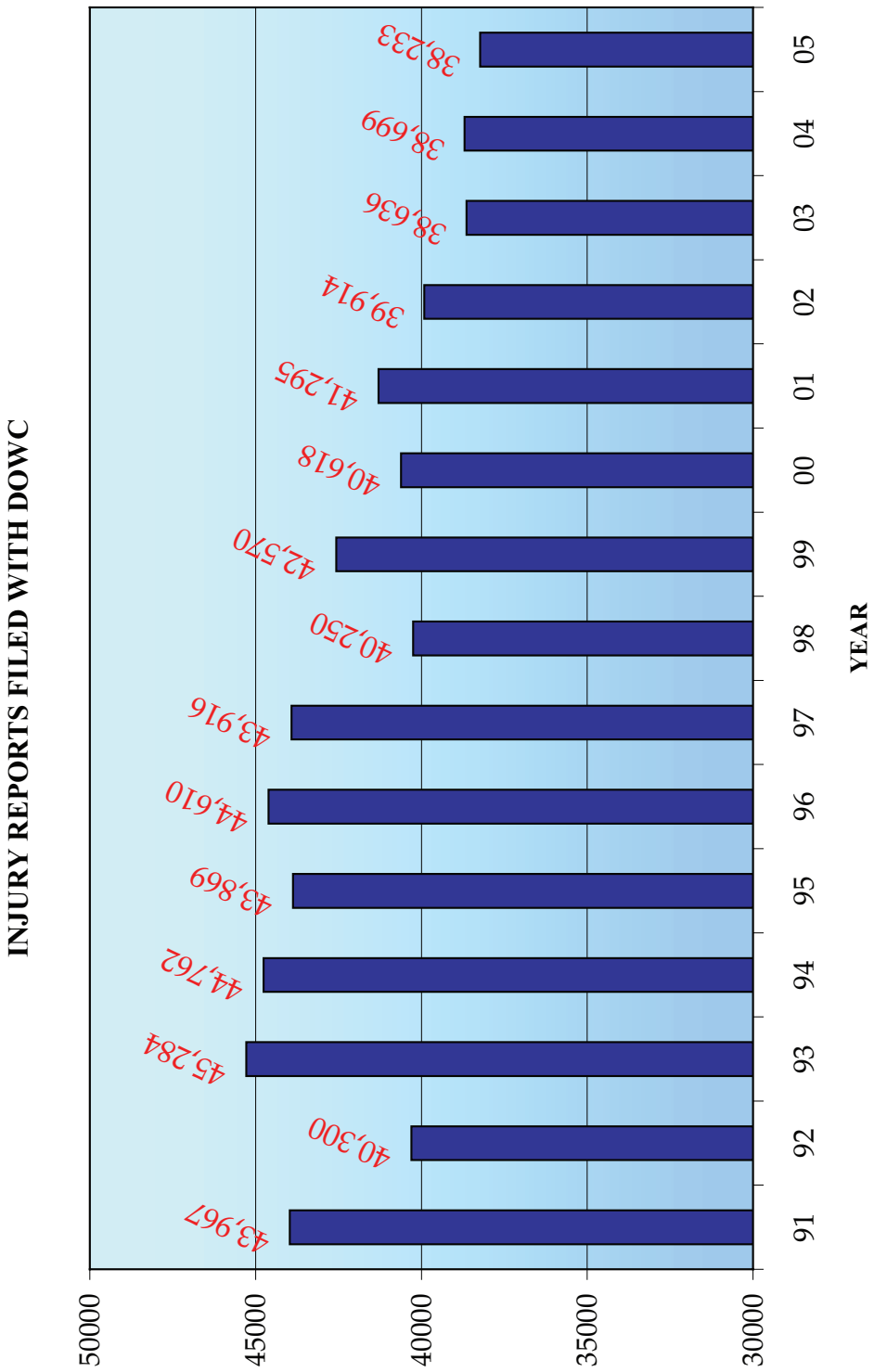
Scheduled impairment is calculated by using a scheduled number of weeks assigned to the total loss of a body part or function (such as vision or hearing), multiplied by the percentage of the impairment. This amount is then multiplied by a rate that is set by the Division every July.

Whole person impairment is calculated by multiplying the impairment rating by an age factor established by statute, multiplied by 400 weeks, and multiplying the product by the temporary total disability rate.

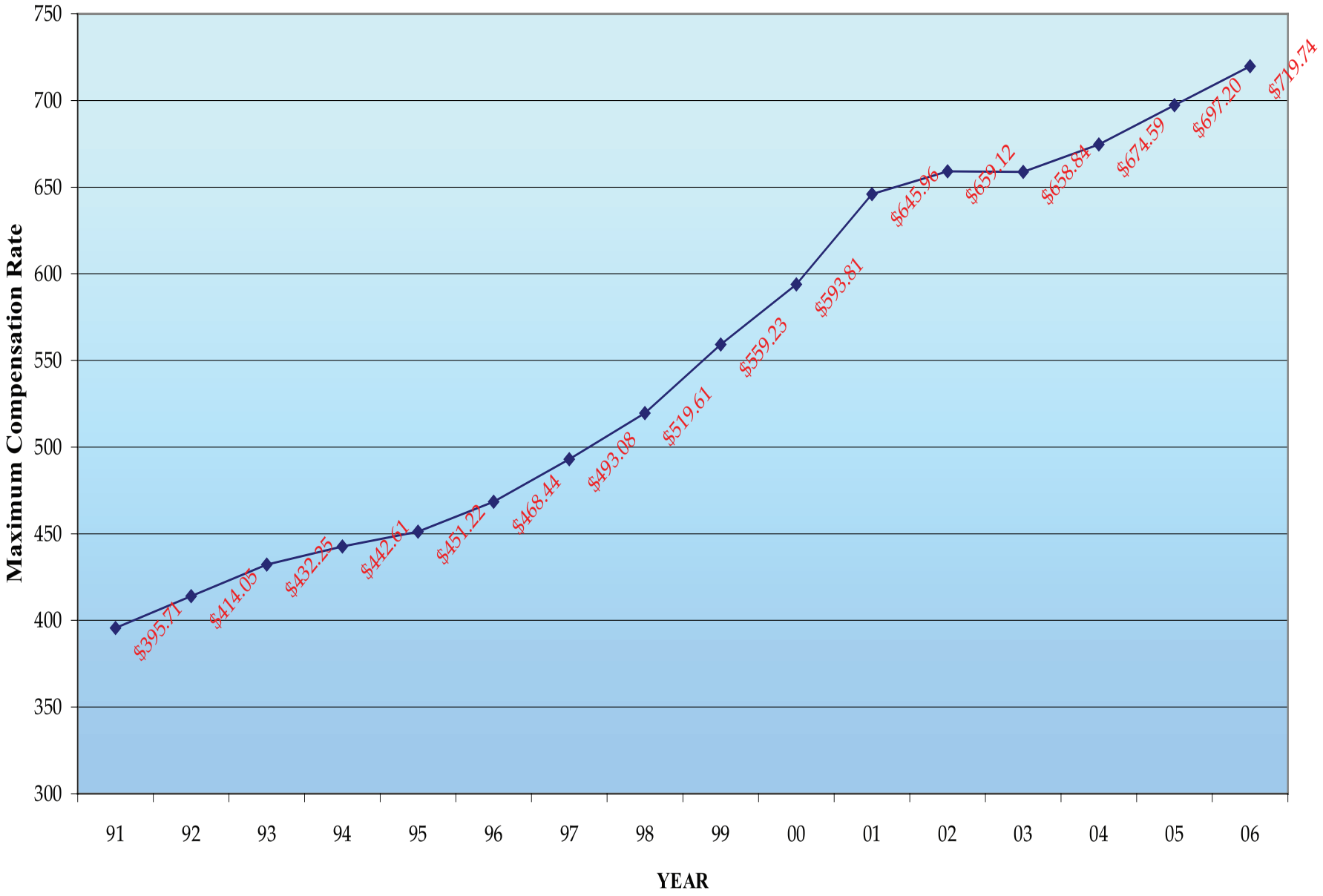
Permanent Total Disability (PTD) benefits are generally paid for the lifetime of the claimant where an injury results in the inability to earn any wages in the same or other employment. Death benefits are paid to eligible dependents. To avoid duplication of benefits, offsets may be taken for social security or other employer-financed disability benefits.

Permanent Total Disability benefits are generally paid for the lifetime of the claimant where an injury results in the inability to earn any wages in the same or other employment.

By law, all injuries that result in fatality to, or permanent impairment of, or lost time from work for the injured employee in excess of three shifts or calendar days or the contraction by an employee of an occupational disease that is listed by rule, must be reported to the Division. (See chart below.) All work-related injuries need not be reported, since many are medical-only claims that involve less than four days lost time from work and no permanent impairment. In 2002, the Division began to accept electronic injury reports from insurance carriers.



AVERAGE WEEKLY WAGE & MAXIMUM BENEFIT RATES FOR COLORADO



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Access to System Remedies

Workers' Compensation Community

Recognizing the need to implement the new legislation in a meaningful, balanced manner, workers' compensation practitioners representing employers, injured workers, and the medical community, turned out in force, donating hours of free time to Division task forces, committees, and boards. In addition, the community attended countless public hearings to participate in, and ensure the effective implementation of, legislative reform through the administrative rules process.

The community representing the interests of injured workers and employers, attended countless public hearings to participate in, and ensure the effective implementation of, legislative reform.

Physicians from the various specialties, together with Division staff, worked to establish the framework for training and accrediting physicians to treat injured workers and to ensure compliance with the requirements of the Colorado workers' compensation system. The Medical Treatment Guidelines, created to address the most frequent and costly injuries occurring in the system, resulted from the hard work and dedication of a variety of medical disciplines including medical doctors, surgeons, osteopaths, physical therapists, acupuncturists, podiatrists, chiropractors and dentists. The Medical Care Accreditation Commission was created to advise the Director on the medical fee schedule, medical impairment rating guidelines, the aforementioned medical treatment guidelines and utilization standards. Several years following implementation of the measures for which it was created, the commission was repealed. The group consisted of physicians licensed to practice medicine in this state, consumers representing risk management and small business, as well as members representing injured workers and the insurance industry.

Rules of Procedure

Massive rule changes were necessary to implement the reform legislation of 1991. Subsequent refinements to this large piece of legislation, and corresponding modifications to rules, would also occur in the years that followed. Because of the many changes and overlays to existing rules since 1991, the Division in 2004, embarked on an effort to simplify language, update policy, harmonize format, regroup and renumber the rules in a more logical sequence.

It began with more than 6 months internal work by division staff to produce a draft set of rules for review by the community. The Director released the draft both in electronic and hard copy both to individual self-insured employers, risk managers, physicians, insurance carriers, health care professionals, employers, attorneys, adjusters and professional associations representing these groups (e.g., the Colorado Self Insured Association, the Workers' Compensation Coalition, the Colorado Medical Society, the Colorado Municipal League, the US Chamber of Commerce, and the Colorado Association of Commerce and Industry.)

When the first formal notice of rule-making was published on July 10, 2005, the Division had already exceeded the Administrative Procedures Act requirement for making rules available 5 days prior to hearing, by over 15 months.

Revisions to the Colorado Workers' Compensation Rules of Procedure, went into effect on January 1, 2006.

Customer Service

The Division of Workers' Compensation is committed to promoting excellent customer service to the community. In a system as complex as workers' compensation, complete information and efficient service are the keys to early resolution of disputes and reduction of costs. The Division created the Customer Service Unit in November 1991 to establish a centralized source for inquiries and distribution of public information on workers' compensation issues. During that first year, The Customer Service Unit consisted of 3 employees who received 21,400 phone calls and helped 16,580 customers in person. During the following fiscal year, the number of customers tripled as the unit helped 115,626 customers by phone and in person. Additional employees were added to the unit as it had appeared the public found a valuable source of information. For the next five years from 1993 through 1997, they continued to show growth and the Customer Service Unit received, on average, 83,548 phone calls per year or 6,962 per month. Customers in person averaged 7,435 per year or 620 per month. It remains the major source for dissemination of workers' compensation information to the community.

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Customer service representatives help customers by identifying their needs and responding to their requests. In cases involving complex or technical issues, service representatives refer customers to the appropriate unit or individual for assistance. The unit provides informational materials to the public. Copies of the Workers' Compensation Act are available through the Customer Service Unit. Services include:

- Injured workers receive help in filing a claim and information on any questions throughout their claim. Services rendered include explanations of their options and responsibilities, assistance in resolving disputes with the insurance carrier and the options available at the next step in their claim.
- Employers are given information on which occupations and businesses need insurance, how and where to purchase insurance, how to file a claim when an employee is injured, and their responsibilities as employers.
- The unit assists insurance companies with information on claims and correct reporting procedures. They provide technical assistance to insurance adjusters seeking information on the statute, rules, and procedures.
- Attorneys, physicians, medical professionals and the public can obtain general workers' compensation information as well as specific answers to inquiries.

Customer Service Calls and Walk-in Customers

Fiscal Year	Number of Phone Calls	Number of Walk-in Customers
1998-1999	77,132	6,653
1999-2000	76,810	5,961
2000-2001	72,604	5,942
2001-2002	68,898	6,298
2002-2003	65,273	5,727
2003-2004	59,708	5,567
2004-2005	56,763	5,446
2005-2006	51,541	7,089

The decrease in the number of phone calls and walk-in customers, tends to be matched by the increase of website visits and requests for publications. Colorado has been in line with the national trend of fewer workforce injuries resulting in fewer claims filed. The Customer Service Unit has done 3 separate customer service surveys in the last 9 years and the unit always receives high marks in the area of customer satisfaction. The surveys show 96% to 98% of customers are very satisfied or satisfied with the information received.

Website

With links and various drop-down choices on the site, injured workers no longer have to maneuver through information that isn't relevant to them. Instead, there are pages specifically created for their needs.

Providing information in a variety of formats for use by the community is critical to meeting the needs of a diverse workforce and employer base. In keeping with that idea, and in addition to making information available in person, by phone and through publications, the Division increased its web presence from what was little more than an online bulletin board, to a needs-based approach to assist online customers by asking, "How may we help you?

With links and various drop-down choices on the site, injured workers no longer have to maneuver through information that isn't relevant to them. Instead, there are pages specifically created for their needs. Likewise, other stakeholders such as insurance adjusters, medical providers, attorneys and employers have their own pages containing information that is most helpful to them.

The site can be accessed at www.coworkforce.com/dwc/

Throughout the new site, terms, procedures and the laws governing the workers' compensation system are clearly explained. Going forward, this greatly improved web-site will serve as the focal point for the launch of other services and reflects the evolving vision of the Division of Workers Compensation. Though it is still a work in progress, it provides a one-stop portal for workers' compensation resources to help injured workers, attorneys, adjusters and health care professionals.

Publications

The Director's Interpretive Bulletins are an effort to provide guidance on the practical applications of the Colorado Workers Compensation Act through the Director's interpretation of how the Colorado system is intended to operate.

The Division provides a wide array of publications to educate the public on workers' compensation procedures and requirements. The Director's ***Interpretive Bulletins*** are an effort to provide guidance on the practical applications of the *Colorado Workers Compensation Act* through the Director's interpretation of statute and other factors affecting the system. The purpose is to provide greater levels of consistency and predictability as to how the Colorado system is intended to operate. At the same time, the annual ***Work Related Injuries in Colorado*** provides a statistical snapshot of Colorado for a specific year and answers such questions as: *What is the Distribution of Fatal Claims by Gender, by Age by Education?*

The ***Adjusters Guide*** was created as a practical handbook specifically designed to direct claims adjusters on claims handling processes consistent with statutory and rule requirements. It provides specific information on the correct methods for calculating, paying and terminating benefits to ensure the timely delivery of medical and compensation benefits to injured workers where liability has been established. The Division's ***All About Claims Newsletter*** is utilized to provide updates to claims adjusters as well as attorneys representing both injured workers and employers. ***Electronic Broadcasts*** or e-mail announcements, are utilized to immediately provide interpretive bulletins and workers' compensation notices, as well as announce educational offerings, seminars, and news items to those individuals who have requested information in this format. Other publications include:

- **Workers' Compensation Act**
- **Employer's Guide**
- **Workers' Compensation Insurance Requirements for Employers**
- **Loss Prevention and Loss Control Manual**
- **Self-Insurance Information and Application**
- **Work Related Injuries in Colorado**
- **Employee's Guide***
- **So, You are Thinking of Representing Yourself in Your Workers' Compensation Case...***
- **Essentials of the Premium Cost Containment Program**

Also available in Spanish

Research and Statistics

The goals of the Research and Statistics unit are:

- to provide information about workers' compensation upon request from customers including business firms, insurance carriers, private citizens, attorneys, and the executive and legislative branches of state government;
- to assure accurate, reliable information is available; and,
- to increase the effectiveness and efficiency of the Division by providing professional assistance to other units in the development and implementation of program evaluation measures.

In addition to these functions, every year, the Research & Statistic unit publishes a report *Work-Related Injuries in Colorado* - which provides comprehensive analysis on various aspects of workplace injuries such as nature of injury, part of body, industry, gender, etc. This report is often used by customers to assist in providing information on potential legislation concerning workers' compensation, research studies, and educational purposes. A copy of the report can be found on the Division's website.

Cost Containment

Medical Cost Containment

Access to quality healthcare is a necessary concern of the workers' compensation system. The most truly cost effective medical care is the care that gets the injured worker healed and back to work as quickly, and as wholly, as possible. At the same time, healthcare costs have always been an important portion of workers' compensation expenses. Healthcare was a natural issue for the 1991 reform legislation to take under consideration. Therefore a variety of healthcare programs were instituted or reemphasized in the new Division of Workers' Compensation under SB91-218 as a mechanism for ongoing medical cost containment.

Since the 1991 reform it is undisputed that medical cost inflation has been greater than inflation for other goods and services. There are a variety of factors that impact the cost of medical care and the upward pressure on health care costs continues. Workers' compensation is only a tiny percentage of total healthcare costs. As such, the workers' compensation system cannot maintain access to quality care without being competitively priced. Thus, although a variety of cost controls can be and have been implemented in workers' compensation, the base costs for medical services are still greatly influenced by the general healthcare market.

The legislature at the time of SB91-218 incorporated several changes to give the Colorado workers' compensation system the tools to create a balance between reasonable cost and access to quality health care. These programs, taken as a whole, have apparently been effective: The National Council on Compensation Insurance stated at its June, 2006, State Advisory Forum, that Colorado's proportion of medical costs compared to indemnity costs (51% to 49%) is quite good relative to the regional average of 66% medical costs to 34% indemnity costs. (Some of this difference may also be a result of Colorado's relatively high wages, compared to other nearby states.) As the nation's healthcare delivery systems as well as medical treatment protocols and technologies are constantly changing, vigilance and flexibility is necessary to maintain effective health care cost containment programs.

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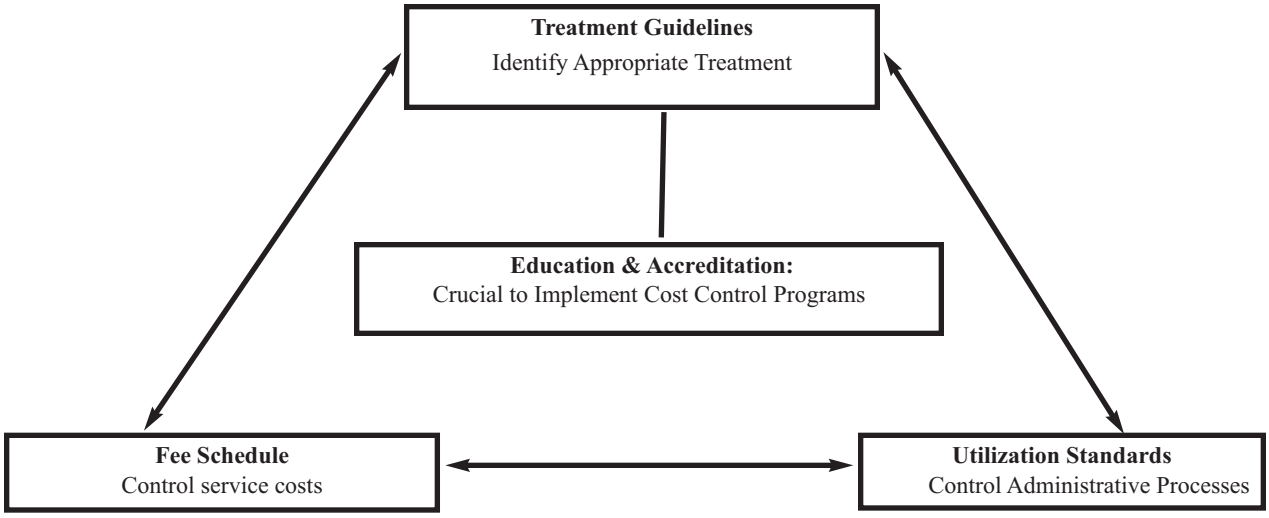
PROGRAMS TO CONTROL MEDICAL COSTS



The cornerstones of the medical policy programs (the treatment guidelines, the fee schedule, and the utilization standards) work together in controlling costs. These programs are designed to identify and enforce the appropriate medical services and number of treatments, to control the costs of individual services, and to create administrative procedures that keep friction costs as low as possible. All of these programs rely on the education of the workers' compensation community and the accreditation of its physicians to implement them effectively.

SB91-218 incorporated the following cost containment programs with their attendant purposes:

- Impairment Rating Guidelines--to establish a uniform, equitable system for evaluation of permanent impairment.
- Physician Accreditation--Level I--to teach physicians their legal, administrative and medical roles in workers' compensation, and Level II--to teach physicians how to calculate impairment ratings based upon guidelines in the curriculum and the AMA Guides to the Evaluation of Impairment, 3rd Edition Revised.
- Independent Medical Examinations--to resolve disputes concerning Maximum Medical Improvement and Impairment Ratings.
- Medical Fee Schedules--to establish maximum fees for medical, surgical, hospital, nursing, dental, facility and vocational rehabilitation services.
- Treatment Guidelines--to identify medically appropriate diagnostic tests and therapeutic treatments for high cost and high frequency injuries and/or diseases.
- Utilization Standards--to guide administrative processes and control costs, and thereby to clarify uses of services not specified by treatment guidelines.

Physician Accreditation Program

Colorado leads the nation in workers' compensation medical cost containment as the first state to develop and implement a Physician Accreditation Program. The main objective of this innovative approach is to reduce the escalating costs of health care and decrease costly litigation in the workers' compensation system by assuring that participating physicians are adequately educated on workers' compensation issues.

SB 91-218 established the Physicians' Accreditation Program to provide physicians with an understanding of the administrative, legal and medical aspects of workers' compensation. There are two "tiers" of accreditation: Level I and Level II. Level I educates providers about the legal and medical aspects of the workers' compensation system, and how they may practice effectively within that system. For some, such as chiropractors and podiatrists, Level I ensures that they receive reimbursement for treating "lost time" injuries (those rendering the patient unable to return to work for more than three working days). Level II accreditation is sought by licensed MDs/DOs and is required to evaluate impairment of injured workers. The training focuses on the application of rules, treatment guidelines, and impairment rating protocols to the medical cases presented, with the objectives of achieving maximum improvement in the injured workers and consistency in rating impairment.

The Physician Accreditation Program provides physicians an understanding of the administrative, legal and medical aspects of workers' compensation.

Accreditation is accessible to every licensed physician with consideration of specialty and geographical diversity. To become accredited, physicians are required to successfully complete an examination.

The total number of physicians participating in the accreditation program has fluctuated over the years. By 2006 approximately 1,100 physicians held Level I or Level II accreditation, participating from all geographic areas of the state. While the majority of Level II physicians practice in occupational medicine or in specialties focused on treating the musculoskeletal system, there are other participating physicians such as specialists in ophthalmology, ear nose & throat, dermatology, pulmonology, neurology and psychiatry.

In addition to its mandate of providing accreditation training to medical providers, for the past several years, the Accreditation Program has been formally disseminating information about impairment ratings to other workers' compensation constituents. In 2000, the program offered its first seminar called "Impairment Ratings for Non-Physicians," oriented to professionals such as attorneys, insurance adjusters, paralegals, nurse case managers, and non-physician medical providers such as physical and occupational therapists, physician assistants, nurse practitioners, and psychologists. A number of similar public seminars were offered in the following years, including several on new or updated Medical Treatment Guidelines. The Program also invites non-physician medical providers to audit its Level I and Level II courses as another forum to learn about the Division's medical programs and the impairment rating process.

In the new century the Accreditation Program also took advantage of the growth of the Internet and other technologies, and accomplished the following:

- Added the list of accredited physicians to the Division's website, in a searchable format;
- Added an e-version of the Level I and Level II Accreditation Curriculums to the Division's website;
- Made available a video depicting the impairment rating instructional lectures presented at the 2004 Level II Accreditation seminar;
- Created and added other instructional materials to the Division's website to support and clarify the impairment rating process;
- Developed a database of e-mail addresses of accredited physicians to more efficiently communicate with and keep physicians updated;
- Developed an internet-based Level II Reaccreditation course.

In 2002-03, the Physicians' Accreditation Program was subject to a Sunset Review by the Department of Regulatory Agencies. As a result of the review, the Program was statutorily extended to year 2014.

Independent Medical Examination Program

The findings of the IME physician can be only be overcome by clear and convincing evidence.

The Division Independent Medical Examination Program (DIME) is an important tool in medical cost containment. Prior to the 1991 reform, disputes on medical issues were generally resolved by "dueling doctors" appearing before an administrative law judge. Following the SB 218 mandate for the creation of the DIME program, disputes regarding the attainment of maximum medical improvement (MMI) and/or whole person impairment must go through the DIME process before the parties can go to hearing. Further, the DIME physician's opinion on those issues must be afforded great weight and can only be overcome by clear and convincing evidence.

The DIME program became functional on May 22, 1992. The statute and corresponding rules that govern this program have gone through some modification over the years. The Division maintains a list of Level II accredited doctors to perform DIMEs. Colorado was the first, perhaps the only, state that requires doctors who are on such a list to have the special training that goes with being accredited.

If either party disputes the authorized treating physician's findings regarding either MMI or whole person medical impairment, the party can request a DIME. Following legislation that passed in 1999 the parties can, by mutual agreement, select any independent physician to perform the exam. However, if the parties cannot agree they can obtain a physician to perform the exam from the list maintained by the Division. The current process is that, based on geographical location and necessary specialization, the parties are given a list of 3 physicians. Each party strikes one name and the remaining doctor performs the exam. The Division tracks the DIME whether it is conducted by an agreed upon physician or a doctor from the Division list.

The number of DIMEs requested varies, but since 1994 the average has been about 3,873 per year. Over the years there has been an average of about 200 accredited doctors on the Division maintained list. The number of instances where the parties agree upon a medical examiner fluctuates each year, but recently has been around 15-20%

It is interesting to note that the party that most often requests the DIME has reversed over the years. In 1993 and 1994, the vast majority of DIMEs were requested by the insurers. Thereafter, the trend started to change and in the last couple of years claimants have been responsible for around 87% of the DIMEs requested.

In 2001-02, the Division promulgated a rule and instituted a process whereby a claimant deemed indigent could obtain a DIME without paying the cost up front.

The statute requires that the party requesting the DIME must pay the physician for the exam and that payment must be made before the exam takes place. In 2001-02 the Division promulgated a rule and instituted a process whereby a claimant deemed indigent could obtain a DIME without paying the cost up front.

Staff in the Division's DIME unit reviews all the DIME reports for basic completeness and compliance with the AMA Guides impairment rating protocols. If the report is incomplete or is not in compliance with proper impairment rating protocols it may be returned to the physician to be completed. Once it is complete the DIME unit sends a notice to all parties.

Medical Treatment Guidelines

Senate Bill 218 mandated the creation of Medical Treatment Guidelines for the most frequent and high cost injuries and diseases occurring in workers' compensation. The Medical Treatment Guidelines (MTGs) have been established as exhibits in the Workers' Compensation Rules of Procedure and are reviewed regularly to incorporate current medical research and community practice standards.

The guidelines are based on the evaluation of medical research by the Division and input from various experts within the Colorado workers' compensation health care community. Using this information, medical treatment guidelines are developed to identify the indications and contraindication of diagnostic tests and treatments, as well as, if applicable, an optimal and usual maximum number of services for a given diagnosis.

Each of the Medical Treatment Guidelines is written to assist both physicians and non-healthcare professionals. While medicine is an art and not every person will respond to treatment in the same manner, the MTGs provide guidance regarding what treatments are generally considered reasonable and necessary for a particular condition. Thus, the MTGs have become very successful in assisting physicians, case managers and adjusters to communicate regarding the treatment of injured workers. The Division has received a great deal of praise regarding the quality of its MTGs. Providing the MTGs helps to avoid unnecessary litigation, as well as unwise or unnecessary treatments.

By providing these guidelines, unnecessary litigation, as well as unwise or unnecessary treatments, are avoided.

The Division has fully implemented and published 10 Medical Treatment Guidelines. The guidelines developed for different injuries include: Low Back Pain, Lower Extremities, Reflex Sympathetic Dystrophy/Complex Regional Pain Syndrome, Traumatic Brain Injury, Cervical Injury, Chronic Pain Disorder and Upper Extremities. The Upper Extremities Guidelines include sections covering Occupational Carpal Tunnel Syndrome, Thoracic Outlet Syndrome, Cumulative Trauma Disorder, and Shoulder Injury. The Division also developed a Guideline for Functional Capacity Evaluations.

Impairment Rating Guidelines and Use of the AMA Guides

Another component of the 1991 reform legislation was that impairment rating guidelines were mandated to ensure that "injured workers who have like injuries also receive like impairment ratings." These guidelines, set in rule, work in conjunction with the Physician's Level II Accreditation Curriculum to direct Level II Accredited physicians on how to determine and report an injured worker's percentage of permanent physical impairment based upon the American Medical Association's *Guides to the Evaluation of Permanent Impairment, Third Edition, Revised*.

Use of these guides ensure that "injured workers who have like injuries also receive like impairment ratings."

Medical Fee Schedule

The Medical Fee Schedule (MFS) is mandated by statute and establishes a maximum dollar allowance for health care services and procedures provided by physicians, non-physician providers, hospitals, and dentists in the Colorado workers' compensation system. The statute requires that the Director review the fees on an annual basis. Data from a large sample of workers' compensation cases is analyzed by Division staff every year as part of this review.

In 2006, the Division added significant specificity to its facility fee schedule. The Division moved from a straight per diem or percentage of billed charges, to a simplified use of Medicare's facility fee structure. The structure relies on the diagnosis and procedures involved in each case to set the facility fee, including inpatient, outpatient, urgent care and emergency room facilities. Colorado is one of only a few states that use the Medicare system in workers' compensation individualized for each hospital in the state, and the only state found that includes Urgent Care facility fees.

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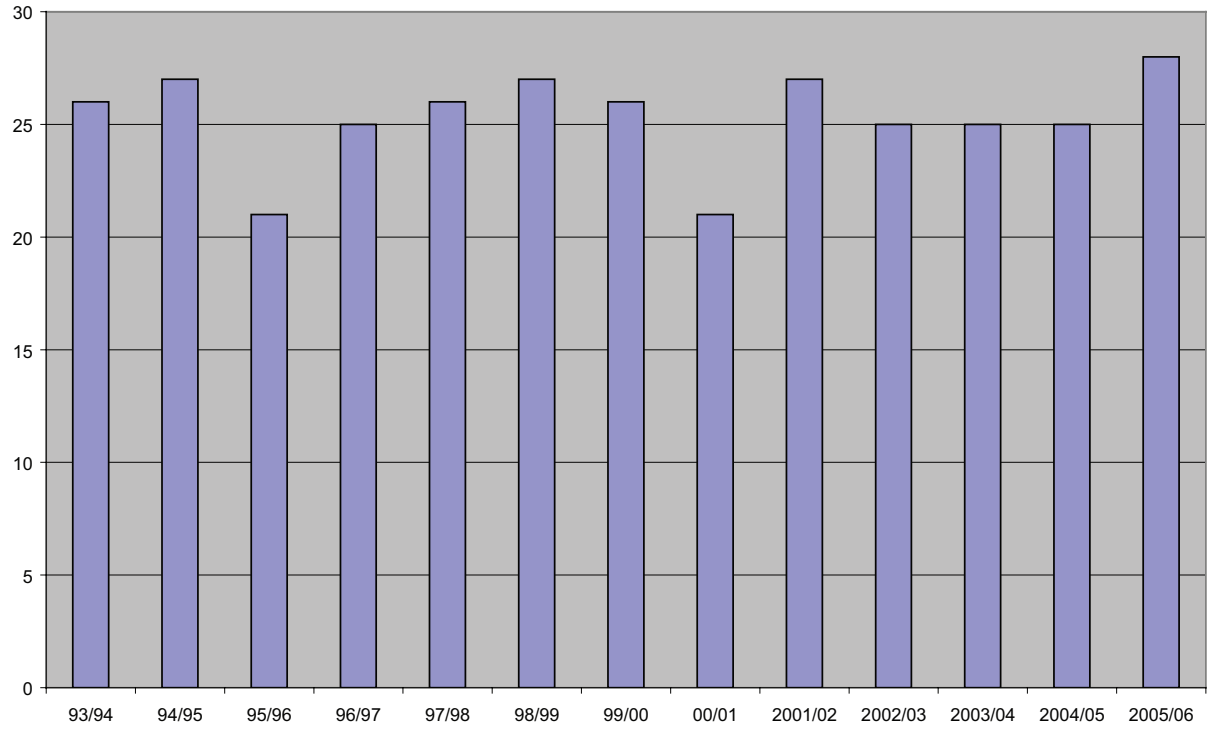
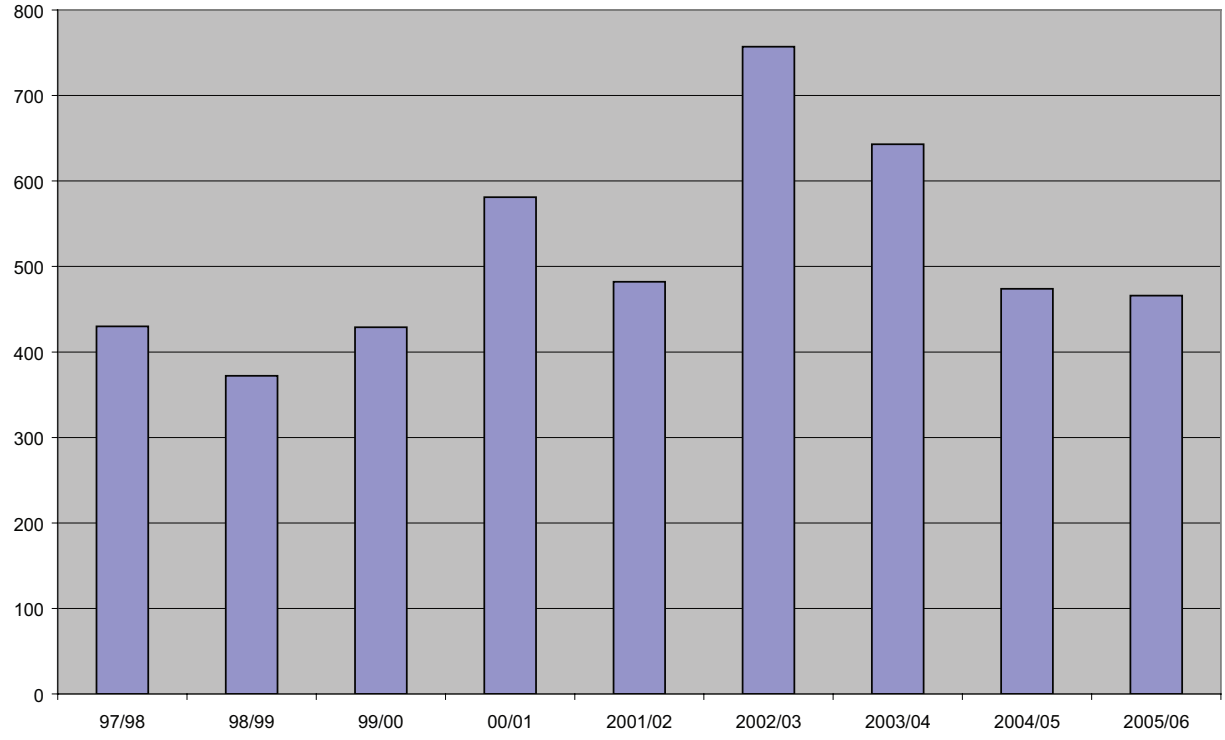
Each year since FY93/94, the Division assesses the effectiveness of its MFS by requesting from several large carriers and third party bill review companies the percentage saved during the previous year due to the use of our MFS. During the last year, the savings was 28% (on over $410 million of billed charges in this sample, more than $115 million was saved). Since FY93/94, the savings have always been at least 21%, with the average savings per year being 25%.

The telephone calls, emails and letters answered by the MFS unit are logged each year. Using these logs, the Division has been able to identify and address problem areas, as well as clarify and simplify the language in the MFS. The Division has put more information on its website and increased the number of seminars and lectures it presents regarding the MFS. As a result, the number of questions and disputes has decreased.

Percentage of Savings from Medical Fee Schedule



Number of Disputes Addressed from Medical Fee Schedule



Medical Utilization Review Program

The Medical Utilization Review Program is yet another program established to reduce the costs of medical care and litigation. It provides a mechanism to review and remedy medical services that may not be reasonable and necessary. Enacted in 1988, it is a peer review and medical dispute resolution program designed to evaluate a health care provider's treatment of an injured worker.

The program provides a mechanism to review and remedy medical services that may not be reasonable and necessary.

Any insurer, self-insured employer or claimant may request a medical utilization review. Utilization review proceedings may result in a change of provider, a retroactive denial of fees charged by the provider, and/or a revocation of the provider's accreditation from the Division. The results of a utilization review proceeding are set forth in an order by the Director based on the recommendations of a panel of peer health care providers.

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Premium Cost Containment

In the ten-year period ending in 1988, workers' compensation insurance premiums paid by Colorado employers increased over 400 percent, and all indications were that this uncontrolled rise in rates would continue. To provide incentive for Colorado employers to put into place a standardized loss prevention/loss control program, the General Assembly of the State of Colorado passed the Workers' Compensation Cost Containment Act. The Act was designed to help employers lower their costs associated with workers' compensation insurance coverage by reducing the frequency and severity of on-the-job injuries.

The positive risk management decisions the Cost Containment Program promotes are important for the long-term prosperity of individual companies and the overall state economy.

The positive risk management decisions the Cost Containment Program promotes are important for the long-term prosperity of individual companies and the overall state economy. The Workers' Compensation Cost Containment strategy to reduce accidents and injuries, and at the same time lower costs, is based on factors of loss prevention and loss control that all employers can easily manage without interfering with their company's normal business operations. Since the best method of avoiding the high costs of accidents and injuries is to prevent them from occurring, an effective safety program means putting into action a plan that involves everyone in the workplace. In addition to preventing employees from being injured, other reasons for the employer to take part in the Cost Containment program are the financial savings and increased profits that result from effective risk management.

Workers' Compensation Cost Containment Program Certification requirements amount to basic, but sound, principles of risk management, which should be a part of any business plan. The requirements are: (1) a formal declaration of policy from top level management placing the safety and well being of all employees at the highest priority, (2) the assignment of a safety coordinator or safety committee, (3) loss prevention rules which have been fully explained to employees on a general and task specific basis, (4) safety training for all employees, general and task specific, (5) designated medical provider with emphasis on physicians knowledgeable in industrial medicine, (6) claims management procedures which emphasize early intervention, follow-up with injured employees, and modified duty in coordination with the designated medical provider. Applicants for certification must provide documentation to the Cost Containment Board. The documentation must affirmatively support dates, signatures, meeting minutes, contracts, and loss information. Division technical support personnel also conduct on-site presentations, workshops, and program monitoring and make individual reports to the board concerning the applicant's request for certification.

This cost control program is available at no cost to the employer and provides for an opportunity for a reduction in premium of up to 10%.

This cost control program is available at no cost to the employer and provides for an opportunity for a reduction in premium of up to 10%. Employers who have an approved program in place for a full year and who have demonstrated success in preventing and controlling losses are granted a cost containment certificate. All workers' compensation carriers who sell coverage in Colorado are required, by law, to inform policyholders of the availability of this program.

The cost savings directly attributable to this program are realized in several ways such as a reduction in an employer's experience modification factor, a reduction in the employer's industry rates, and a credit applied to the employer's workers' compensation premium. The indirect cost savings are realized by reduced or eliminated: down time, retraining time, and property damage.

By implementing the six-step safety program, employers have been able to successfully lower their claim costs as well as lowering their frequency of claims.

It has been demonstrated that the Colorado Workers' Compensation Cost Containment Program is effective at reducing the frequency and severity of claims of Colorado employers. By implementing the six-step safety program, employers have been able to successfully lower their claim costs as well as lowering their frequency of claims.

Statistics include the cumulative savings the program is responsible for since its inception in 1990. As of July 2006 the total certified employers in Colorado is 4,427. The total cumulative reduction in claim costs is over $170 million. The total cumulative reduction in claims frequency is over 15,000.

Self-Insurance Program

A growing number of employers are choosing to self-insure their workers' compensation programs and are finding that this approach can save money and improve overall claims management. There are risks, but the benefits can be substantial.

Self-insurance is not actually insurance, but rather an alternate means by which an employer may fund the payment of workers' compensation benefits. In all but two of the fifty states, employers meeting certain standards may self-insure workers' compensation instead of purchasing commercial insurance. In Colorado, self-insurance started with the enactment of the first workers' compensation law. This statute allowed any employer who had accepted the provisions of the law permission to self-insure for payment of compensation and benefits. In early 1991, there were 82 active workers' compensation self-insurance permit holders. Currently there are 101 active self-insurance permit holders.

The Colorado Workers' compensation statute allows employers who meet strict financial and loss control standards to become self-insured. Placement of the self-insurance program with the Division of Workers' Compensation administrative body is consistent with the practices of other states and jurisdictions that allow self-insurance of this risk. Self-insurance can be a costly endeavor and not a "cure-all" for all companies, nor an advantage for every company. Each company must consider its own unique situation when considering self-insurance.

ADVANTAGES FOR EMPLOYERS TO SELF-INSURE WORKERS' COMPENSATION

- **Quicker admission, payment of disability, and return to modified duty**. When a company chooses to self-insure, they generally take a more active role in educating their workforce about safety issues and helping injured employees make faster transitions back to work. Well-managed plans can help companies save money through reduced expenses and increased productivity.
- **Investment dollars do not go to prepay insurance.** In a traditional insurance model, a company pays premiums to an outside carrier, which that firm invests to generate income. When a company chooses to self-insure their losses, they can take advantage of this same investment and cash-flow opportunity.
- **Increased program efficiency and direct incentive for loss control.** Companies choosing self-insurance can not only reduce or eliminate certain commercial insurer expenses, but also provide stronger oversight of claims, loss control, and workplace safety services. While a self-insurer may need to outsource claims management to a third-party administrator, it is in a better position to control decisions on injury compensation, settlements, and legal activity.

Self-insurance is not actually insurance, but rather an alternate means by which an employer may fund the payment of workers' compensation benefits. There are risks, but the benefits can be substantial.

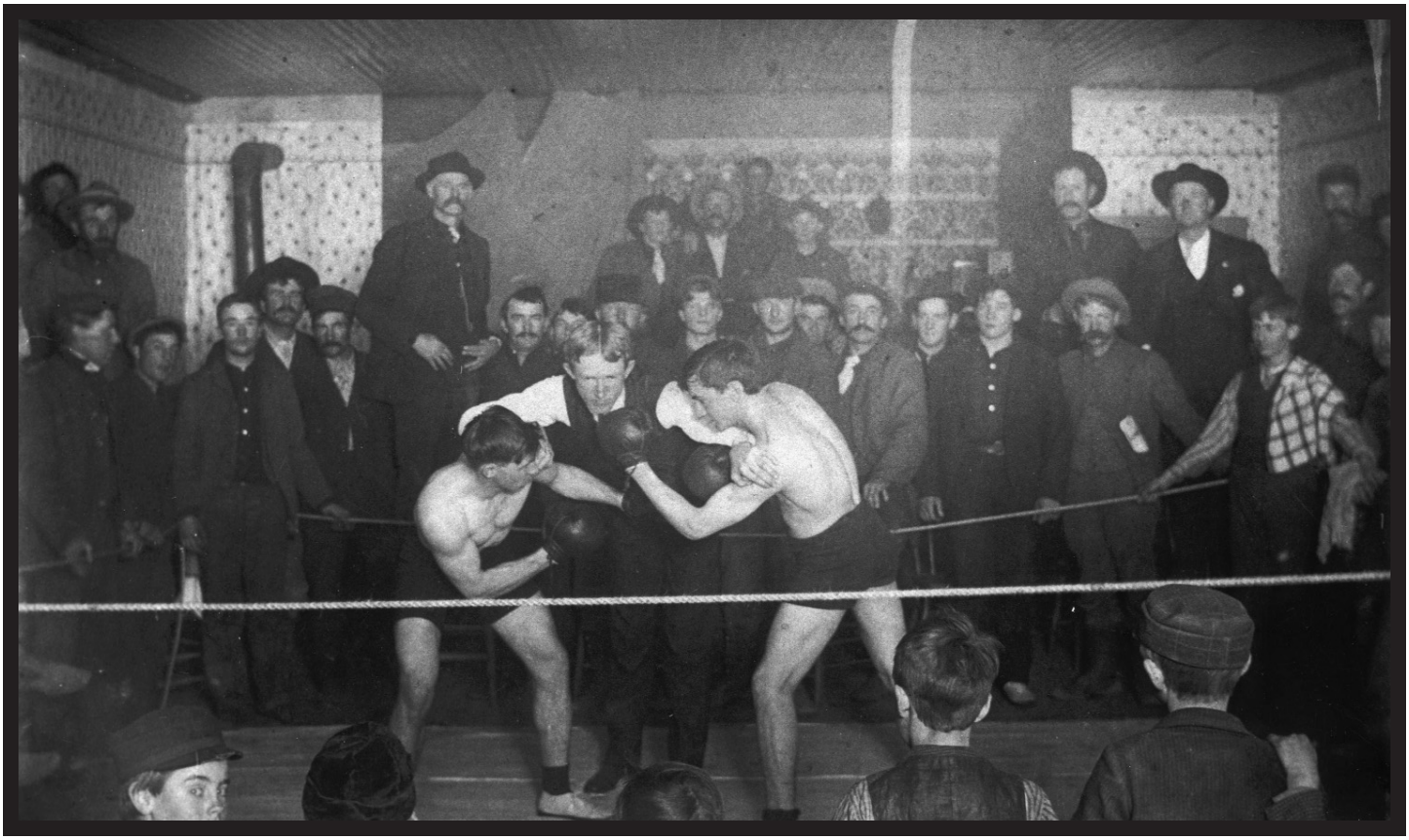
DISADVANTAGES FOR EMPLOYERS TO SELF-INSURE WORKERS' COMPENSATION

- **Increased financial exposure to adverse loss.** In a self-insured plan, a high volume of serious and catastrophic losses can have a devastating impact on a company's financial stability.
- **Increased administrative burden.** A self-insured program usually requires active involvement from senior management and financial staff members. This may require some companies to hire additional staff to handle the additional administrative duties.
- **Regulatory restrictions.** There can be several restrictions placed on a self-insured employer, including the need to provide financial security, subject the company's claim handling programs for a regulatory audit, as well as other oversight of the program in general.

CRITERIA FOR SELF-INSURANCE IN COLORADO INCLUDE:

- Applicant/employer must show a solid financial position with strong financial ratios
- Applicant/employer must demonstrate a successful safety and loss control program
- Applicant/employer must have 300 employees regularly employed in Colorado
- Applicant/employer must have been in business for at least five year
- Applicant/employer must maintain competent claims adjusting
- Self-insurance permits are reviewed no less than every year

One of the major challenges of the Colorado Division's self-insurance program is the determination of an adequate amount and appropriate type of security required for a self-insured company. If the security amount is excessive, it can be a financial burden on the self-insured company. However, it is crucial that the security amount be adequate to cover all workers' compensation expenses in the event that a self-insured company becomes unable to meet their workers' compensation financial obligations. This is an area of self-insurance that requires ongoing evaluation and research.



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Litigation Reduction

Prehearing

Prehearing Conference

Although the general statutory authority for prehearing conferences predates SB 91-218, the Division of Workers' Compensation began in July 1991 to aggressively promote this method of alternative dispute resolution. More specific statutory authority was added in the 1994 legislative session. The result is a successful program that provides a reduction in workers' compensation litigation.

Parties set prehearing conferences to resolve disputes about legal procedures, to get a judge's perspective about the strengths and weaknesses of each party's evidence and legal arguments, and to resolve or narrow disputed issues through consensus or by order of the judge.

Prehearing Conferences provide the parties to a claim a forum for informal meetings with an administrative law judge. Conferences are set at the request of a party, and the judge may order the opposing parties to attend and participate. Parties set prehearing conferences to resolve disputes about legal procedures, to get a judge's perspective about the strengths and weaknesses of each party's evidence and legal arguments, and to resolve or narrow disputed issues through consensus or by order of the judge. Many prehearing conferences result in full and final settlement of the case.

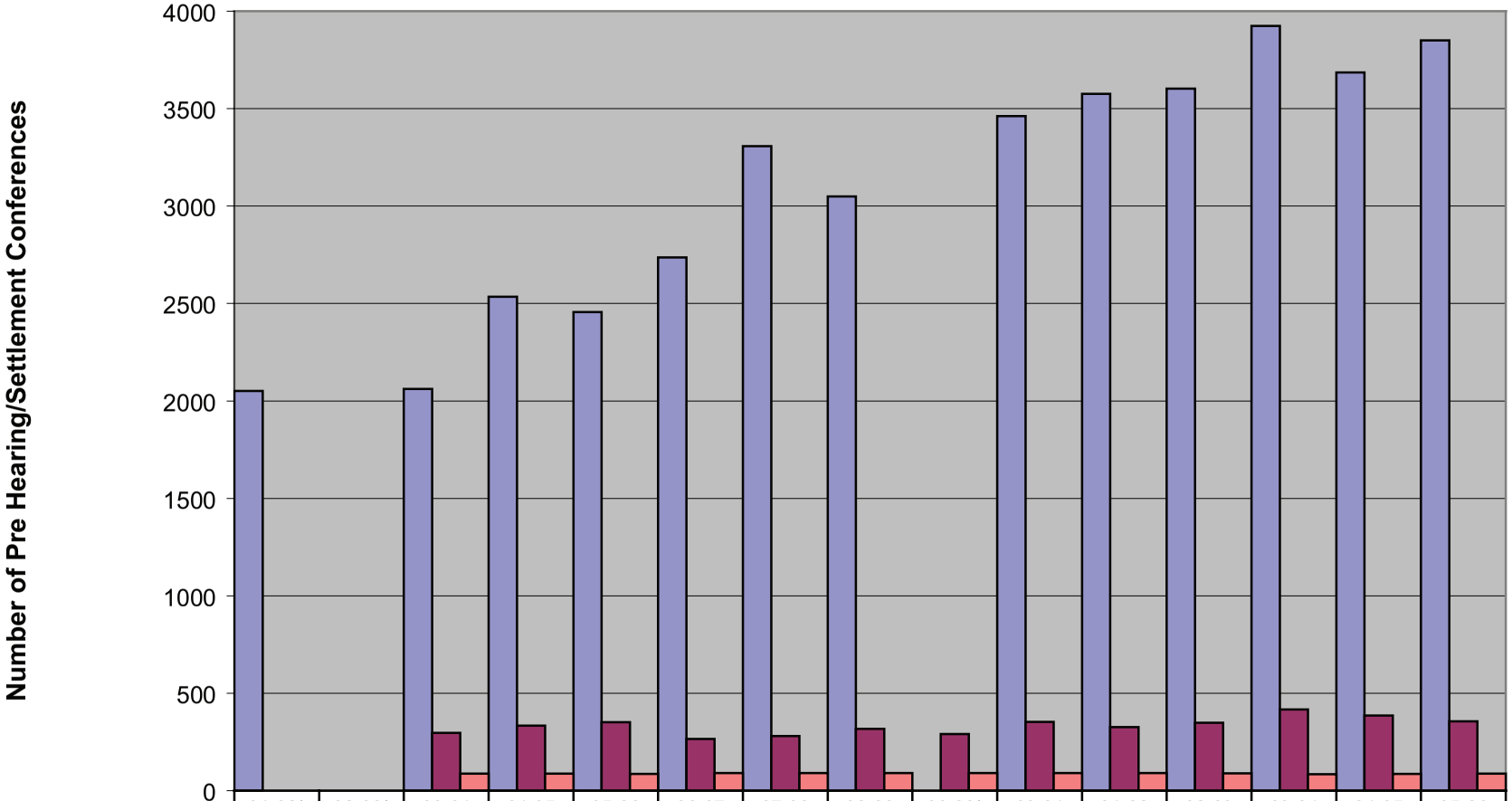
The Division judges also rule on motions filed outside the context of a prehearing conference. Resolving matters through prehearing conferences and written motions reduces the number of issues that proceed to litigation.

Settlement Conference

The judge helps the parties weigh the risks and costs of litigating issues and encourages resolution of the claim through consensus and settlement.

Settlement Conferences provide the parties to a claim a forum to discuss settlement and to obtain an independent evaluation of the merits by a judge. These conferences are voluntary, and are scheduled only when all parties agree to participate. Participants typically include injured workers, attorneys and insurance adjusters. Settlement discussions are confidential and cannot be used as evidence in a hearing. The judge facilitates an exchange of information and helps the parties examine the merits and weaknesses of the respective positions. The judge helps the parties weigh the risks and costs of litigating issues and encourages resolution of the claim through consensus and settlement. Settlement documents in which all parties are represented by counsel, unless settlement was finalized before an administrative law judge, are filed with the Division of Workers' Compensation for approval.

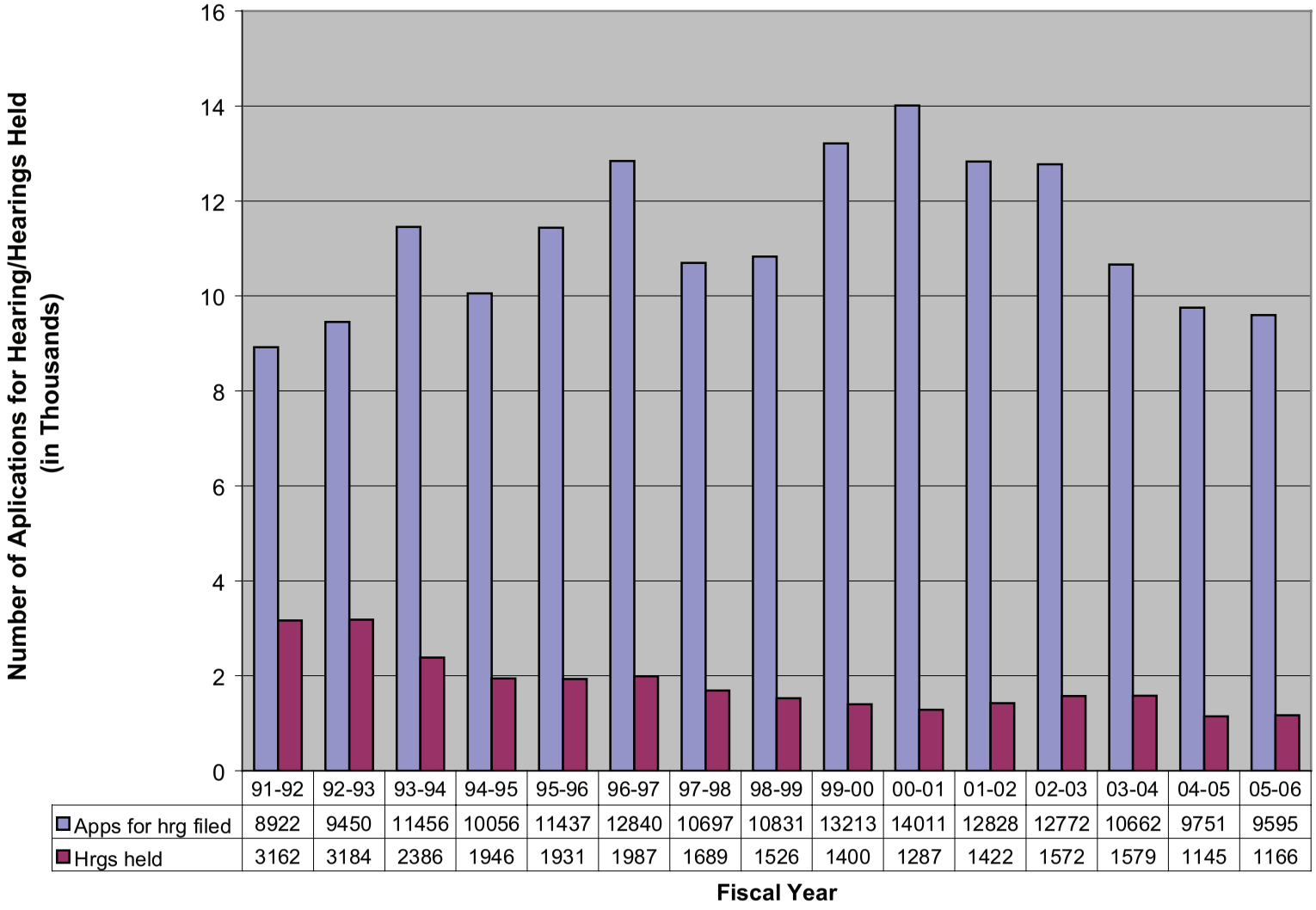
Comparison of Pre Hearing & Settlement Conferences to Hearings



	91-92*	92-93*	93-94	94-95	95-96	96-97	97-98	98-99	99-00*	00-01	01-02	02-03	03-04	04-05	05-06
PHC/STC held	2051		2062	2535	2456	2736	3308	3049		3461	3576	3602	3925	3685	3850
PHC/STC & hrg			296	334	351	266	280	317	290	353	327	348	417	386	356
% PHC/STC no hrg			86.8	86.8	85.8	90	90	90	91	90	91	89	85	86	87

*Data figures are unavailable for portions of this fiscal year.

Comparison of the Numbers of Applications for Hearing versus the Number of Hearings Held



	91-92	92-93	93-94	94-95	95-96	96-97	97-98	98-99	99-00	00-01	01-02	02-03	03-04	04-05	05-06
Apps for hrg filed	8922	9450	11456	10056	11437	12840	10697	10831	13213	14011	12828	12772	10662	9751	9595
Hrgs held	3162	3184	2386	1946	1931	1987	1689	1526	1400	1287	1422	1572	1579	1145	1166

Claims Management

The primary objective of Claims Management is to provide administrative oversight and dispute resolution based on the legislative mandate that active management of workers' compensation claims should be practiced to expedite and simplify the processing of claims, reduce litigation, and better serve the public.

Claims Management is dedicated to cost containment based on the following objectives:

- Quick, no cost claim resolution;
- Oversight and enforcement of the statute and rules through claims review;
- Reviews of insurers' claims-adjusting practices with clearly defined consequences for failure to pay benefits timely or to correct improper practices; and, information and technical assistance about workers' compensation benefits and access to dispute resolution services.

The Claims Management Unit completely reorganized the philosophy of claims handling at the Division to incorporate the directive in SB 91-218 to establish strong administrative oversight. Using the technology of the computer system, the unit began to develop a comprehensive system of claims monitoring and enforcement with increased emphasis on early dispute resolution, customer service and community education. An important element in the 1991 legislation was the adoption of a penalty provision which could subject a party to penalties of up to $500.00 a day for failure to cooperate or comply with claims management efforts to manage claims or complaints.

The purpose is to define the baseline for appropriate claims-adjusting practices and to reduce litigation through communicating and enforcing these requirements at the administrative level.

A section dedicated to claims adjusting requirements was added to the Division's rules. The purpose was to define the baseline for appropriate claims-adjusting practices and to reduce litigation through communicating and enforcing these requirements at the administrative level. The Claims Management Unit began publication of an adjustor newsletter directed at keeping insurance adjusters informed of new policies and issues.

Claims Managers intervene to ensure compliance with all benefit and reporting requirements including the payment of medical, temporary, disfigurement and permanent benefits. Lump sum awards are calculated and complaints are handled as they arise. In the last 4 years, 20,116 issues have been handled and resolved by this unit.

Beginning in 1993, the unit initiated a comprehensive project to review all admissions of liability. The goals of this project were to ensure that benefits were calculated accurately, termination of benefits properly supported and admissions filed pursuant to statute and rule. Following review, carriers were alerted to over and underpayment of temporary and permanent disability benefits. They were required to make corrections or provide additional information to support their calculation.

As the process continued, the system became more refined. In 2002, the Division implemented a program to track issues that the Division handled and resolved. In addition, the Division implemented a sampling method for admission review, so that resources can be deployed to review the admissions that are most likely to contain mistakes.

The results show there are significant under and overpayments that can cost millions of dollars to the system. The initiation of this project confirmed the continuing need for strong administrative oversight resulting in remediation and enforcement.

From 1993 through 1999, the correction of underpayments to claims due to admission review totaled over 16 million dollars. During the same period, the correction of overpayments by admission review resulted in savings to insurance carriers of over 3 million dollars . From 2000 through 2005, the correction of underpayment of claims due to admission review, was over 12 million dollars. Overpayments were over 2 million dollars. The Claims Unit continues to refine the admission review process, incorporating education and tracking patterns of practice.

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Enforcement and Compliance

Coverage Enforcement

Most Colorado employers, with limited exception, are required to carry workers' compensation insurance. Employers with one or more full or part-time employees, are required to have workers' compensation insurance. An employer's failure to comply leaves workers unprotected and provides for unfair competition to other employers who meet their obligations.

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The Division of Workers' Compensation enforces coverage requirements with all employers and insurance companies. Employer wage records are cross-checked with employer insurance policy data. In addition to the cross-check system, investigations are initiated from complaints received through telephone calls, letters, walk-ins, website feedback, industry concerns, and non-insured claims. Employers who do not appear to have coverage are notified of statutory insurance requirements and subsequent fines and penalties for failure to comply.

An employer who is subject to the statute and who has allowed their insurance policy to lapse or who has never had coverage is subject to fines, penalties, and closure action. House Bill 2005-1139 became effective July 1, 2005, instituting mandatory fines for failure to obtain or maintain coverage. Fines are up to $250.00 per day if the employer fails or has failed to have coverage for the first violation, with fines between $250.00 and $500.00 per day for subsequent violations. A non-insured employer may also face a cease and desist order to stop business operations until insurance is obtained.

In January 2006, the Division added a new tool to its website www.coworkforce.com/dwc Visitors to the website can verify workers' compensation coverage on-line. The Division provides informational presentations at no cost to businesses and groups around the state regarding workers' compensation insurance requirements and various exemptions.

Since the passage of HB 2005-1139 (Fiscal Year 2005/2006) over 32,000 initial contact letters were sent to employers. The number of *Notice to Show Compliance* letters sent to employers was 792. In 180 of those cases, a *Specific Findings of Fact, Conclusions and Order to Pay Fine* has been issued by the Director.

Carrier Practices

Creation of the Carrier Practices Unit was the direct result of the 1989 John Lewis study commissioned by the legislature. The "Final Report of the Independent Study of the Colorado Workers' Compensation System" recommended, "[o]ne method of developing compliance with benefit and reporting requirements is the use of a carrier and self-insurer practices unit within the Division [that] . . . would have authority and responsibility for investigating individual carriers and self-insurers to determine whether they are handling claims properly, both with respect to specifically identified provisions in the law or as to general practices. . . ."

The Carrier Practices program directly impacts how insurance companies adjust claims. Following reform legislation in 1991, members of the Carrier Practices Unit conducted presentations to inform insurance claims managers and administrators, medical providers, and other members of the workers' compensation community of changes in the law that mandated active claims oversight and audits by the Division.

Comprehensive compliance audits began in 1994 after audit rules were first promulgated based on recommendations from a task force comprised of Carrier Practices auditors and representatives from insurance carriers, self-insured employers, and the claimants' bar. Carrier Practices auditors conduct audits of insurers' administration of workers' compensation claims. The auditors identify claims deficiencies and determine compliance levels in areas critical to proper claims management, reporting, and benefit delivery. Compliance levels of at least 90% are considered acceptable. The auditors measure insurers' compliance with statutory and rule provisions and take necessary steps when compliance levels are below standard. Insurers may be required to correct deficient claims and pay compensation found owed but not properly paid as well as to make corrections based on audit recommendations in order to meet and maintain acceptable compliance levels.

Since 1992, Carrier Practices auditors have conducted 210 training sessions and presentations. In addition to training adjusters, presentations have been before associations, coalitions and conferences. Insurance adjusters may be directed to undergo training specific to audit results.

Since 1994 the Carrier Practices Unit has conducted 238 claims compliance audits of insurance carriers, self-insured employers, and third-party administrators. Section 8-43-304(1.5)(a) was added in 2005 and provides the Director with authority to fine an insurer who knowingly or repeatedly violates any provision of the Act. An insurer whose audit reflects claims handling practices below acceptable compliance levels is notified that failure to improve performance could be considered knowing and willful. A subsequent audit that again falls below expected compliance levels could result in the imposition of a fine.

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Special Funds

The Special Funds Unit is a grouping of individual funds, with specific criteria and guidelines for admission. Each fund's mission is to provide medical care and/or compensation payments to some of the most seriously injured workers in Colorado. These programs have their own funding sources.

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THE MEDICAL DISASTER FUND

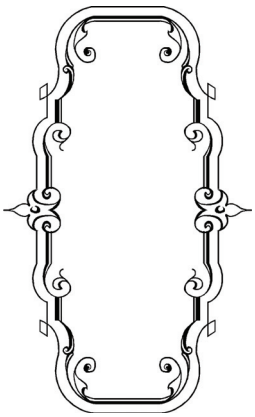
The Medical Disaster Fund (MD) was established in 1965 to provide relief to employers and insurance companies who expended a certain dollar amount in medical expenses on industrial injury cases. Initially, the limit was $2,500 per case but increased to $3,500 on May 6, 1965. On May 27, 1967, the threshold was raised to $5,000. There is a cap on the total dollars that can be spent on medical expenses on these cases. This amount was initially $35,000, but increased to $55,000.

THE MAJOR MEDICAL INSURANCE FUND

The Major Medical Insurance Fund (MMIF) was created to replace the Medical Disaster Fund for injuries occurring from July 1, 1971, through June 30, 1981. The initial threshold was $7,500 per case, but was raised to $20,000 on July 1, 1973. The intent was to provide a mechanism for funding medical expenses of catastrophically injured workers while not imposing an impossible burden on the employer or insurance carrier. (In 1971, $20,000 of medical expense was catastrophic. In today's inflated world, an outpatient surgery alone can cost that much.) There is no cap on the dollar amount that can be expended. This Fund is closed to any cases with injuries occurring after June 30, 1981.

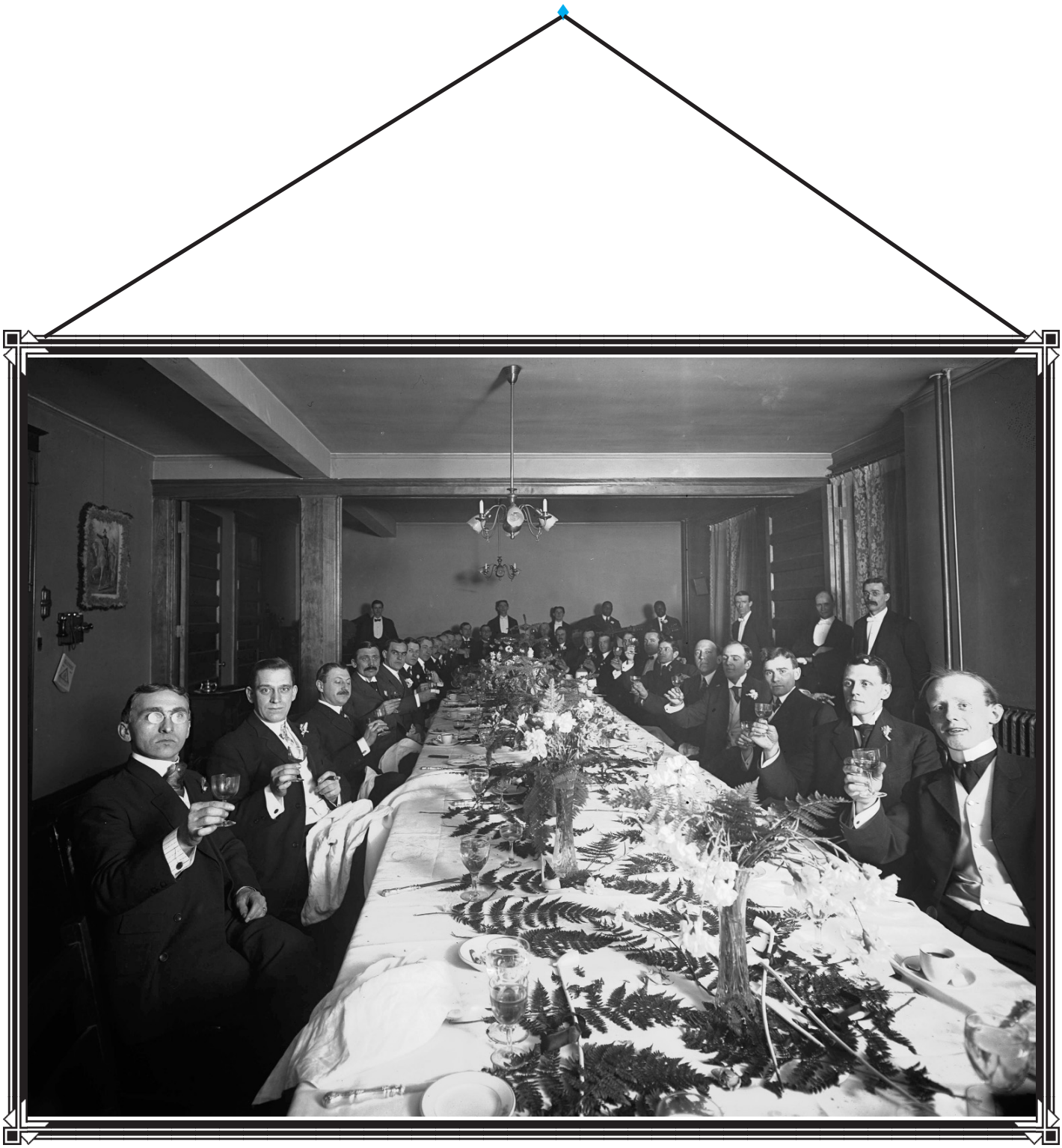
THE SUBSEQUENT INJURY FUND

The Subsequent Injury Fund (SIF), which is similar to "Second Injury" Funds in other states, was established by SB 45-205 on April 9, 1945. The initial intent of the Fund was to aid employers who hired amputees who sustained second amputations and were no longer able to work. The concept developed to include relief for employers hiring workers who had been permanently but partially disabled from an industrial injury and then sustained another injury that resulted in permanent total disability.



The Subsequent Injury Fund paid the lifetime portion of the permanent disability that was attributable to all but the most recent injury. Thus, all the claimants in the Subsequent Injury Fund are permanently and totally disabled from more than one industrial injury.

Inclusion of "listed occupational diseases" resulting in permanent total disability occurred later. When a worker develops a specific occupational disease (anthracosis, silicosis, asbestosis and radon diseases such as cancers) and has documented exposure with more than one employer, the Subsequent Injury Fund assumes payment for the medical and compensation expenses after $10,000 has been spent by the employer or insurance carrier. This fund closed to trauma injuries occurring after July 1, 1993 and to occupational diseases occurring after April 1, 1994.



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Organizational Chart