Colorado Division of Workers Compensation

Fee Schedule & Admin changes

Chronic Pain Disorder/CRPS

Kathryn Mueller, MD, MPH, FACOEM
Medical Director
Professor,
University of Colorado Denver
Changes to Rule 16 “Utilization Standards” and Rule 18 “Medical Fee Schedule”
Effective: 1/1/2012
Copyright Notice

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“Handling, Processing and Payment of Medical Bills”

- Prior authorization required for
  - BR (By report)
  - RNE (Relativity Not Established)

- Payer and provider shall negotiate an amount by:
  - Using a similar existing code with established RVUs;
  - Justifies the difference in value”

- If no established RVUs are reasonably similar
  - Payer and provider may agree to the amount to be paid

- “If no established similar CPT© exists and no agreement between the provider and payer exists
  - the payer shall pay the billed amount.”
Changes to Rule 16-9 (E) “Prior Authorization”

Supporting medical documentation is defined as documents used in the provider’s decision-making process to substantiate the need for the requested service or procedure and includes:

- “An accurate definition or description of the procedure; and”
- “Documentation of the relevant diagnostic or surgical indications as listed in the medical treatment guidelines; and”
- “Justification for any variance in an established procedure when appropriate; and”
- “A listing of any similar procedure and value; and”
- “The justification for the difference in the value.”
Changes to Rule 18-1&2

Updated the following “incorporated by reference” documents:

- **2011 edition** of the “Relative Values for Physicians” (RVP©)

2% in all Conversion Factors

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Change to Rule 18-5(F)(2) 
“Pathology Section”

ADDED TWO (2) NEW: “Drug Testing Codes and Values”

Replaces CPT© codes 80100 and 80101

Modeled after Medicare’s new drug testing codes and fees.
Change to Rule 18-5(F)(2) “Pathology Section”

**Maximum Values for the two new Drug Screen Tests codes:**

- G0434 $27.66
- G0431 $138.28

*Only one unit of service can be billed per patient encounter*

- Regardless of the number of drug classes tested; and
- Irrespective of the use or presence of the QW modifier
Change to Rule 18-5(F)(2)(a) “Pathology Section”

G0434:

- **Simple drug testing methods** (including dipsticks, cups, cards, cassettes, etc, that are interpreted visually, with the assistance of a scanner, or are read utilizing a moderately complex reader device outside the instrumented laboratory setting (i.e., non-instrumented devices))

- **Classified as CLIA moderately complex tests.**

- **Qualitative drug screen tests that are waived under CLIA.**
Change to Rule 18-5(F)(2)(c) “Pathology Section”

G0431

- Qualitative; Multiple drug classes by CLIA high complexity test (no CLIA classified “moderate tests”) method such as a multi-channel chemistry analyzers, where a more complex instrumented device is required
  - e.g., immunoassay, enzyme assay
  - Not CLIA Waived (no QW modifier allowed)
  - Performed using instrumented systems that are capable of withstanding repeated use
Change to Rule 18-5(I)(1) “Evaluation & Management Section (E&M)”

**ADDED a NEW “E&M Documentation Guidelines” added as Exhibit #7 to Rule 18 and the first sentence edited as follows:**

- Medical Record documentation shall encompass the “E&M” Documentation Guidelines criteria as adopted in Exhibit #7 to this Rule 18 to justify the billed Level of E&M Service.
Use either Medicare’s 1997 E&M Documentation Guidelines (specialist) or Exhibit #7.

Consistent With CPT with more Occupational Medicine needs incorporated

Consistent With Medicare’s 1997 E&M Documentation Guidelines
E&M Level of Service

*Can be determined using the documentation of these three relevant and legible key components:*

- History,
- Exam, and
- Medical Decision Making (MDM)
  
  (Requires all three key components for initial visits or two of the three key components for follow up to be at the same level or higher)

*or*

- Time if > 50% of the visit is face to face with injured counseling or coordination of care. 
  Document Time
Listening to the Injured Worker and Clarifying Complaints

**Chief Complaint**:  
- How the accident occurred  
- What hurts and or what injury(s) were sustained;

**History of the Present Illness/Injury(s) (HPI)**  
- Location and Context  
- Quality and Associated Signs  
- Severity and Modifying Factors  
- Duration and Timing
Listening to and Clarifying the Injured Workers Complaints/Injury(s)...

To obtain a “Extended” History of the Present Illness/Injury(s) (HPI) Level:

- **Initial visit requires:**
  - Discussion of *the causality* of the injured workers’ work related injury(s) as they relate to the injured worker’s job duties.

- **Established visit requires:**
  - A detailed patient specific description of the *patient’s progress with the current treatment plan*, which should include *objective functional gains/losses, ADL’s etc.*
Review of System - ROS

The list of system remains consistent with CPT and Medicare’s 1997 E&M Documentation Guidelines. Identify, perform and document of all pertinent ROS systems with either a positive or negative response is necessary to be counted. Determine and document if anything has changed since the last visit in established patients.
Past Family Social Histories (PFSH) includes four (4) areas, instead of three (3)

#1 Past and Current Medical History
- Past surgeries or illness or injuries or hospitalizations
- Current Prescription and non-prescription medication
- Any allergies (foods drugs etc..)

#2 Family History
- A review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk
- Any family situations that can interfere with or support the injured worker’s recovery
#3 Occupational Histories

**Current employer**
- # years employed
- # of hrs currently working/day
- job duties/types of work and the # of years/time spent doing these duties

**Relevant Past employment or different types of work**
- # years employed
- # of hrs working/day/years performing job duties or specific types of work

**Example:**
- G&G Construction Company worked construction laying pipes for the past 30 years. No other types of employment
Any hobbies, physical recreational activities
- Regular water or snow skier, - possible problem for a knee issue

Past and present alcohol or tobacco or illicit drug use
- Possible addiction issues

Level of education
- Any transferable skills possibilities if necessary

Marital status and if any, # and ages of children
- Support systems, financial issues

Any significant relationships that will help the injured worker (talk with and through their injuries) cope with his/her injuries
Established Patient Level of History can be facilitated by addressing...

Changes to:
- current status of work; and
- non-work related activities; and
- patient functions
Physical Examination of the Injured Worker refer to:

- Exhibit #7 to Rule 18 or
Physical Examination of the Injured Worker – *Example of a Lumbar Back Pain Physical Exam*

**Male Vital signs (1 bullet for 3):**
- B/P 116/65, Pulse 76 and regular, Respiration – 14 and non-labored,
- Weight – 330 pounds
- Height – 6’0”

**Well groomed, Obese male without any obvious deformities. (1 bullet for comment on appearance)**

**No gait dysfunction noted (1 bullet for comment on “gait and station”)**
Musculoskeletal Examination – (1 bullet for 3 MS assessments of the spine)

- Lumbar spine alignment feels normal with no obvious deformities or masses palpated.
- Pain with bending forward at Flexion approx. 40 degrees, extension 5 degrees and lateral flexion 10 degrees bilaterally
- Lumbar spine paraspinal muscles tender

Neurological Examination – (4 bullets)

- Bilateral Deep tendon reflexes 2+ for Achilles and patellar
- Decreased sensation at the L3/L4 dermatome in his left leg and normal in his right leg
Psychiatric examination – (1 bullet)

- No agitation or anxiety was noted at this visit
- Patient states he is being woken up due to pain in his low back and left leg down to his knee
- Patient states the pain keeps him from participating in his usual fall sport (league football).

Total of 9 bullets for this examination = a “detailed” examination.
Medical Decision Making (MDM) Component – three tables (areas) will determine the Level of MDM

1. # of Diagnosis & Management Options
2. Amount and/or Complexity of Data Reviewed
3. Table of Risk
#2 MDM Review of Medical Records

Document each specific medical record and diagnostic test report reviewed and how they influenced the diagnosis and or treatment.

Reviewed Dr. Jones 7/1/2011 consultation and diagnostic EMG and Nerve conduction test results that indicate the injured worker has a impinged nerve at the cervical spine to determine what/where at cervical level is the impingement occurring.
Significant Time Reviewing Other Provider’s Medical Records

Create a separate report and document:
- The name of the record reviewed (Dr.’s name and the dates of service reviewed)
- A brief description of what was in the record
- Amount of time it took to review all the records in the report.

If time is > 30 minutes this record review could be billed separately under the Non Face-to-Face Prolonged Services codes in the E&M section of CPT. This code represents time that is > 30 minutes.
#1 MDM - Planning Care include Treatment Plans and the Injured Worker!

- *Create treatment goals with the injured worker*. If the injured worker “buys-into” the goals, then they are more likely to follow the treatment plan. *These goals must be realistic, obtainable and measureable.*

- Examples: includes range of motion (ROM), strength, endurance, activities of daily living (ADL), cognition, positional tolerance,

- This creates the basis for evaluating “*positive functional gains*” that are in the Division’s Medical Treatment Guidelines.
Treatment Plan – Examples of PT Measurable and Objective Active Goals includes…

- *Increase ROM from _____degrees to _____degrees or can reach to mid back*
- *Increase right arm lifting from 10 pounds to 50 pounds*
- *3 x/wk for 6 weeks*
- *Patient can touch the floor*
- *Patient can demonstrate proper lifting techniques*
E & M Record should include Documentation of diagnostic tests and treatments (PT, OT and surgeries)

“Medical Necessity” - needs to be clear for all referrals, consultations, tests, and treatments

Active therapies with objective, measureable goals and positive functional gains/losses

Use The Division’s medical treatment guideline “General Principles” when documenting to support proposed test/treatments:

- #4 Active interventions
- #5 Active Therapeutic Exercise Program
- #6 Positive Patient Response

Reference the MTGs for surgical indications or contraindications
Do not Assume Your Care is Automatically Approved because...

- *Its listed in the DWC MTG*
  - “Maximum Duration” or
- Just because the “service/procedure is recommended in an MTG
Graduate the # of Therapies based upon “Positive Functional Gains” from DWC’s MTG.

Initially use the greater # listed in the “Time to Produce Effect” for all of the Active Therapies in the DWC’s MTG, then re-evaluate.

Use Passive Therapies and treatments to facilitate the Active Therapeutic Exercise Programs.

Expand to “Optimum Duration” and “Maximum Duration” or beyond if the injured worker continues to make “Positive Functional Gains”.
Time can Determine Level of Service if...
Educating and/or Counseling or Coordination ...

- Represents > 50% of the visit face to face with the injured worker
- The entire time spent face-to-face with a patient and all education/counseling specific information is documented.
Educating/Counseling the Injured Worker is not a general statement

“An hour was spent with the patient in face-to-face consultation, evaluation, education, coordination of care, counseling and review of MRI films.”

The documentation should encompass at least a paragraph or two.
Educating/Counseling the Injured Worker is patient specific

“Ms Jones and I spent 45 minutes discussing her need to use different tools at work. Reminded her to take five minutes breaks from tool use every hour. She told me she is making progress and can now lift 25 pounds. After work she has trouble cooking dinner for her family of five due to the hand pain.”
Document the Amount of Time Coordinating Care with others!

*Can be used to increase E&M code*

*Coordination of Care represents documentation of who, what, when and where you talked to get the direction of care or services for the injured worker.*

- other health care providers, adjusters, attorneys, etc..
Patient Education and Counseling Can facilitate Patient Recovery and Return to Work
Express to the Injured Worker what is expected of them...

Educate the injured worker on:
- Physical functional goals and the likelihood of achieving improved ability to perform ADLs and or work activities
- Pre and post operative functional treatment plans, home exercise requirements.
- The length of partial and full disability expected post-operatively

Refer to the Division’s Medical Treatment Guidelines and use them when educating the injured worker.

Documentation allows you to remind the patient of their responsibilities - discussed and agreed to when developing the treatment plan or prior to surgery.
Change to Rule 18-6(F)(4)(a) “Permanent Impairment Rating”

“Extensive medical records take longer than 1 hour to review and a separate report is created. The separate report must document each record reviewed, specific details of the record reviewed and the dates represented by the record(s) reviewed. The separate record review can be billed under special reports for written report only and requires prior authorization and agreement from the payer for the separate record review fees.”
Change to Rule 18-6(O) has a New Title “Drugs and Medications”

Maximum Fees are still AWP + $4.00 Dispensing fee

- AWP maybe determined using one of the different sources, such as Medispan or RedBook
- First Data Bank no longer publishes AWP
- If AWP goes away, then Whole Sale Acquisition Cost (WAC) + 20% to substitute AWP in this rule.
Change to Rule 18-6(O) has a New Title “Drugs and Medications”

The most significant change is based upon which NDC should be reported:

- Original Manufactures NDC or
- “Repackaged” NDC.

The new rule makes a distinction between what NDC should be billed based upon whether the injured worker is in the “Acute” phase or the “Chronic” phase of care.
Change to Rule 18-6(O) has a New Title “Drugs and Medications”

Acute is defined as 30 days after date of injury.

The billed NDC can be any packaged or repackaged NDC code and the associated fee would be the AWP for that NDC code.

Chronic is defined as 30 days after the date of injury.

Only the original manufactures NDC code, no repackaged NDC codes, and the associated AWP value is allowed.
Change to Rule 18-6(O) has a New Title “Drugs and Medications”

(4) **Compounded Drugs maximum fees** :

- **Category I** – Any anti-inflammatory agent or agents in combination with any local anesthetic agent or single agent (singluar)
  - Z790 Fee $75.00/30 day supply

- **Category II** – Any anti-inflammatory agent or agents in combination with any local anesthetic agent or agents (plural)
  - Z791 Fee $150.00/30 day supply

Change to Rule 18-6(O) has a New Title “Drugs and Medications”

(4) **Compounded Drugs**

- **Category III** – Any single agent other than anti-inflammatory agent or local anesthetic, either alone, or in combination with anti-inflammatory or local anesthetic agent
  - Z792 Fee $250.00/30 day supply

- **Category IV** – Two or more agents that are not anti-inflammatory or local anesthetic agents, either alone or in combination with other anti-inflammatory or local anesthetic agents.
  - Z793 Fee $350.00/30 day supply
On the plus side, you've cured my back pain.
What is Chronic Pain?

Chronic pain - "pain that persists for at least 30 days beyond the usual course of an acute disease or a reasonable time for an injury to heal or that is associated with a chronic pathological process that causes continuous pain (e.g., reflex sympathetic dystrophy)."

CPD-5
1) Acupuncture

- **Good evidence** - both acupuncture and sham acupuncture are superior to usual care without acupuncture for moderate short-term and mild long-term alleviation of low back pain, neck pain and the pain of joint osteoarthritis (Ernst E 2011; Haake M 2007; Brinkhaus B 2006).
Chronic Pain Disorder
Therapeutic Procedures – Non-Operative

a. **Total Time Frame For Acupuncture and Acupuncture with Electrical Stimulation:**
   - **Time to Produce Effect:** 3 to 6 treatments.
   - **Frequency:** 1 to 3 times per week.
   - **Optimum Duration:** 1 to 2 months.
   - **Maximum Duration:** 15 treatments.
Chronic Pain Disorder
Therapeutic Procedures – Non-Operative

2. Biofeedback

- **Good evidence** - biofeedback and cognitive behavioral therapy are equally effective in managing chronic pain (Hoffman BM 2007).
  - Optimum Duration: 6 to 8 sessions.
  - Maximum Duration: 10 to 12 sessions. Treatment beyond 12 sessions must be documented with respect to need, expectation, and ability to facilitate positive symptomatic or functional gains.
3. **Opioids**: Their use in chronic moderate-to-severe cancer pain is well accepted. Their use in chronic nonmalignant pain, however, is fraught with controversy.

4. **Beware** - the # of deaths from poisoning (including unintentional drug overdoses) approaches the number of deaths from motor vehicle accidents in the US. Most of these deaths are due to the use of prescribed opioids, usually in combination with other respiratory depressants such as alcohol or benzodiazepines (NEJM 363:21, 2010).
Risk Evaluation Mitigation Strategy

- Food and Drug Administration oversight
- Requiring manufactures to develop REM strategies for most opioids
- Physicians should carefully review plans & educational materials
3. **Choice of Opioids**:

- **Some evidence** - long-acting oxycodone and oxymorphone - equal analgesic effects and side effects, although the milligram dose of oxymorphone is $\frac{1}{2}$ that of oxycodone (Hale M 2005).

- When choosing longer acting opioids for chronic pain management it is reasonable to consider cost given the lack of superiority profiles for one medication over another.
Chronic Pain Disorder

Therapeutic Procedures – Non-Operative

- **Tapentadol** is not recommended as a first line opioid for chronic, subacute or acute pain due to the cost, lack of superiority over other analgesics and need for further testing to assess GI effects in comparison to other medications.

- **Buprenorphine** may be used for opioid addiction or habituation treatment in patients with chronic pain.

- Any opioid dose **above 120 mg** of morphine should be very closely monitored (Webster B 2007; Franklin G 2008).
Recommendations for Opioid Use

- **Therapeutic Trial Indications**
  a) The failure of pain management alternatives by a motivated patient including:
    a) active therapies
    b) cognitive behavioral therapy
    c) pain self-management techniques
    d) other appropriate medical techniques.
Recommendations for Opioid Use

b) Physical and psychological or psychiatric assessment including a full evaluation for alcohol or drug addiction, dependence or abuse, performed by two specialists including the authorized treating physician and a specialist with expertise in chronic pain.

c) Drug screening for substances of abuse and substances currently prescribed.

d) Physician prescription Drug Monitoring Program review.

And Yes you do get paid for this – Z code $75

CPD-72
Recommendations for Opioid Use

e. Informed, written, witnessed consent by the patient including the aspects noted above.

f. The trial, usually with a short-acting agent should document sustained improvement
   
a. of pain control, at least a 30% reduction,

   b. and of functional status, including return-to-work and/or increase in activities of daily living.
Recommendations for Opioid Use

i. On-Going, Long-Term Management should include:
   a) Prescriptions from a single practitioner;
   b) Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects;
   c) Ongoing effort to gain improvement of social and physical function as a result of pain relief;
Recommendations for Opioid Use

d) Contract detailing the following:

- Side effects anticipated from the medication;
- Requirements to continue active therapy;
- Need to achieve functional goals;
Recommendations for Opioid Use

Contract Language

Reasons for tapering opioids –
Lack of functional effect at higher doses and for apparent hyperalgesia
Non-compliance with other drug use
Drug screening showing use of drugs outside the prescribed treatment
Requests for prescriptions outside of the defined time frames
Lack of adherence identified by pill count, excessive sedation, or lack of functional gains
Excessive dose escalation with no decrease in use of short-term medications
Recommendations for Opioid Use

- **Use of drug screening initially**, randomly at least once a year and as deemed appropriate by the prescribing physician. (Rolfs R 2010; Canadian Guidelines 2010; Chou R 2009).
- **PDMP review** – *yes think Z-code fee for both*
- **Use limited to two opioids**: a long-acting opioid for maintenance of pain relief and a short-acting opioid for limited rescue use.
- **Sleep Apnea Testing**: type of testing required unclear. Type 3 portable units with 2 airflow samples and O2 saturation device may be useful for monitoring respirator depression secondary to opioids.
e) **Marijuana**: Marijuana use is illegal under federal guidelines and cannot be recommended for use in this guideline. The Colorado statute also states that insurers are not required to pay for marijuana.

f) **Alcohol Screening**: It is appropriate to screen for alcohol use and have a contractual policy regarding alcohol use during chronic opioid management as alcohol use in combination with opioids is more likely to contribute to death or accidents than marijuana.
CRPS Medication management

- Oral burst of steroids used early based on clinical findings
- Tricyclics
- Bisphosphonates for those with osteotrophic changes
- Gabapentin and pregablin – good evidence no difference in effectiveness between gabapentin and amitriptyline
- SNRI’s – duloxetine is not superior to amitriptyline
- Opioids - tramadol
Neurostimulation-Radicular Symptoms

Spinal Cord Stimulator

- **Some evidence** - SCS is superior to reoperation in setting of persistent radicular pain after lumbosacral spine surgery (North R 2005);
- **Some evidence** - SCS is superior to conventional medical management in the same setting (Kumar K 2008).
- **Findings may persist at three years of follow-up in patients who had an excellent initial response and are highly motivated.**
2. Surgical Indications

- Patients with a failed spinal surgery with persistent functionally limiting radicular pain greater than axial pain or Complex Regional Pain Syndrome, who have failed conservative therapy including active or passive therapy, pre-stimulator trial psychiatric evaluation and treatment, medication management, and therapeutic injections.

- Patients with severe psychiatric disorders, and issues of secondary gain are not candidates for the procedure (Kemler M 2000).
Complex Regional Pain Syndrome
Making the Diagnosis

**Confirmed CRPS (formerly RSD)**- complaints of pain, vasomotor/sudomotor findings on exam, and two positive test results – x ray, bone scan, stress thermogram, QSART, sympathetic block

**Specific to CRPS-II** - documentation of peripheral nerve injury with pain initially in distribution of injured nerve

**Sympathetic Pain** - SMP patient has pain complaints, but lacks vasomotor or sudomotor signs, AND has pain relief with sympathetic blocks
Clinical Diagnostic Criteria for CRPS

1) Continuing pain which is disproportionate to any inciting event;

2) At least one symptom in three of the four following categories:
   - Sensory: reports of hyperesthesia and/or allodynia
   - Vasomotor: reports of temperature asymmetry and/or skin color changes and/or skin color asymmetry
   - Sudomotor/edema: reports of edema and/or sweating changes and/or sweating asymmetry
   - Motor/trophic: reports of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin)
Clinical Diagnostic Criteria for CRPS

3) At least one sign at time of evaluation in **two or more** of the following categories:

- **Sensory:** evidence of hyperalgesia (to pinprick) and/or allodynia (to light touch and/or deep somatic pressure and/or joint movement)
- **Vasomotor:** evidence of temperature asymmetry and/or skin color changes and/or asymmetry Temperature asymmetry should ideally be established by infrared thermometer measurements showing at least a 1 degree Celsius difference between affected/unaffected
Sudomotor/edema: evidence of edema and/or sweating changes and/or sweating asymmetry – Upper extremity volumetrics may be performed by therapists that have been trained in the technique.

Motor/trophic: evidence of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin).

Clinical CRPS allows initial treatment with first line medications and sympathetic blocks.
Neurostimulation

- Approximately, **one third to one half of patients who qualify for SCS can expect a substantial reduction in pain relief; however, it may not influence allodynia, and hypesthesia** (North R 2005; Kemler M 2008; Barolat G 1998, 2001; Frey M 2009).

- **Patients with significant limitation due to radicular neuropathic pain due to failed back surgery, after greater than 6 months of conventional management** (North R 2005; Kumar K 2008; Barolat G 1998, 2001; Frey M 2009).
Neurostimulation

- A comprehensive psychiatric or psychological evaluation prior to the stimulator trial has been performed.
  - No indication of falsifying information, or of invalid response on testing; and
  - No primary psychiatric risk factors or “red flags”
  - A level of secondary risk factors or “yellow flags” (e.g. moderate depression, job dissatisfaction, dysfunctional pain cognitions) below the threshold for compromising the patient’s ability to benefit from neurostimulation.
  - The patient is cognitively capable of understanding and operating the neurostimulation control device
Neurostimulation

- The psychologist or psychiatrist performing these evaluations should not be an employee of the physician performing the implantation.
- All reasonable surgical and non-surgical treatment has been exhausted; and
- The topography of pain and its underlying pathophysiology are amenable to stimulation coverage (the entire painful area has been covered); and
- A successful neurostimulation screening test of at least 3 to 7 days (North R 2005; Kemler M 2000, 2008).
Intrathecal Drug Delivery

- Not generally recommended. Requires pre-authorization. It may be appropriate in rare occasions.
- Some evidence of a high rate of infection (33%), which can include meningitis (Rauck R 1993).

CPD-106
Emphasizes principles of self-management

Periodic reassessment of patient’s condition as appropriate

Failure to comply with the elements of the self-management program or therapeutic plan of care may affect consideration of other interventions.
Maintenance Management

1. Home exercise programs and exercise equipment – monitor compliance.
2. Patient Education – 2-6 per year
3. Exercise programs requiring special facilities
   - Continuation beyond 3 months should be based on functional benefit and patient compliance.
3. Psychological management.
   - Maintenance Duration: 6 to 10 visits during the first year and 4 to 6 visits per year thereafter. In cases of significant exacerbation, refer to the psychological treatment section in Therapeutic Procedures, Non-operative.
4. Non-opioid medication management
   - Frequency depends on the medications prescribed.

5. Opioid medication management
   - Maintenance Duration: Up to 12 visits within a 12 month period to review the narcotic plan.

6. Therapy management
   - Active Therapy, Acupuncture, or Manipulation Maintenance
   - Duration: 10 visits for each treatment during the first year and then decreased to 5 visits per year thereafter.
7. Injection therapy

- **Sympathetic Blocks**: Not to exceed 4 to 6 blocks in a 12 month period for single extremity and to be separated by no less than 4 week intervals.

- **Trigger Point Injections**: Not more than 4 injections per session not to exceed 4 sessions per 12 month period.

CPD-112
Maintenance Management

- Epidural and Selective Nerve Root Injections - Maintenance Duration: 2 to 4 injections per 12 month period.
- Zygapophyseal (Facet) Injections - Maintenance Duration: 2 injections per year and limited to 3 joint levels either unilaterally or bilaterally. Injections may be repeated only when a functional documented response lasts for 3 months.
Maintenance Management

- Sacro-iliac Joint - Maintenance Duration: 2 per year injections may be repeated only if when a functional documented response last for 3 months.

- Radiofrequency Ablation /Rhizotomy – Optimum/Maximum duration: twice in the first year after the initial rhizotomy and once a year after up to 12 total.

- Not to exceed 3 levels

CPD-113
Maintenance Management

- **Purchase or Rental of durable medical equipment.**
- **Maintenance Duration:** Not to exceed 3 months for rental equipment.
Administrative Update

2011 Legislation & Rules

Becky Greben,
Manager
Medical Services
Delivery section
Div. of Workers’ Compensation

“These new regulations will fundamentally change the way we get around them.”
(2010 Legislation)
Senate Bill 10-011

Sec. 1 - DIME doctors to provide financial disclosure information upon request by a party

- Rule 11 (DIME Rule) amended to meet this requirement (at 11-3)
- Forms WC179 and 180 created for docs to provide info
- Info to be used by party re: deciding which physician to strike
- Time frame controls

To date in 2011, about 2.5% of DIME cases have involved a Disclosure Request
Sec. 3 - Prohibits communication between doc and employer/insurer unless
- Claimant/patient is present, OR
- Physician makes a written record of communication

Record must be made available to patient in the same manner as they would otherwise have access to medical records under rules or statute.
- No need to automatically send out every record of every communication
- Physician responsible to make the record
- “In-house” industrial clinic physicians- same obligations
Senate Bill 10-012

Amends the penalty provision of the WC Act.

- Increases the “catch-all” penalty provision to a max of $1,000/day

- If an insurer fails to pay medical benefits, the payment of any penalty assessed (i.e., the funds received) may be apportioned between the aggrieved party, the involved medical provider, and the WC cash fund.
Senate Bill 10-012

Changes standard for insurer’s delay of payment of medical benefits from “willfully” to “knowingly.”

Where insurer knowingly delays or stops payment of medical benefits for more than 30 days.

Penalties can be assessed at 8% of the unpaid bill
Senate Bill 10-187

Loss of an eye by enucleation is taken off the list of scheduled injuries; is now a whole-person impairment.

- This doesn’t change what you already do; just continue to take the impairment out to WP; let the adjuster decide how to pay it.
- Up to 10% (whole-person) may be included (combined) for orbital deformity

(see 8.6 p. 172 AMA Guides)
Senate Bill 10-187

- **ADDS the loss of a tooth to the list of Scheduled Injuries**

- **How to rate - - -?**
  - Don’t.
  - Report that one, two or X number of teeth were lost as a result of the injury.
  - Is mastication and diet permanently affected? (Sec. 9.3b p. 180 *AMA Guides*). Maybe not, if there are implants or dentures.
Audio-Recording IMEs

Audio-recording requirement for Respondent-requested IMEs (not DIMEs), enacted in 2009, applies to all claims

- Rule 8-8 et seq. governs the process
- Quirks:
  - Is it a 2nd Opinion or an IME? (on whose referral)
  - “Technology” questions & non-compatible digital formats
  - What if party’s request for the recording is “late”
    - Release it anyway
  - Where to send the recording: When in doubt, send to injured worker (vs. attorney)
  - Remember to retain for 1 year from date of written report
MISC. REMINDERS

*Increasing focus on quality / completeness of final impairment / MMI report. Insurance adjusters under scrutiny.*

- Attach relevant worksheets
- MMI date accurate and consistently referenced? (Same for impairment)
- The perils of “Dictated but not read.”
- Report is attached to insurer’s Final Admission-- all that documentation is for the claimant and so should be clear and complete
Three impairment reports due to Division prior to Dec. 31 of the year of your re-accreditation

- This is a requirement for your re-accreditation to be complete

For questions contact Ellen Oakes at the Division, 303-318-8752.
And another reminder...

“Grover Meds.”

It is possible for a claimant to receive lifetime medical benefits “to cure and relieve the claimant of the effects of the work-related injury.”

Maintenance meds or Tx should not be transferred to private ins. if the continued need for the Tx is due to the work injury.
Main Causes of Erroneous Ratings

- Failure to understand the Guides; the process
- Clinical errors
- Possible bias
- Failure to apply causality analysis correctly
- Apportionment applied incorrectly
- Is info from patient consistent with the record(s)?
- Lack of oversight
Some Solutions

- **Review medical records (yours & others)**
- **Determine MMI at the appropriate time and perform objective rating**
- **Think**—What may be the main source of error in the types of ratings you usually do?
- **Double-check calculations**
- **Education**
- **When in doubt, consult Impairment Rating Tips, then call the Division**