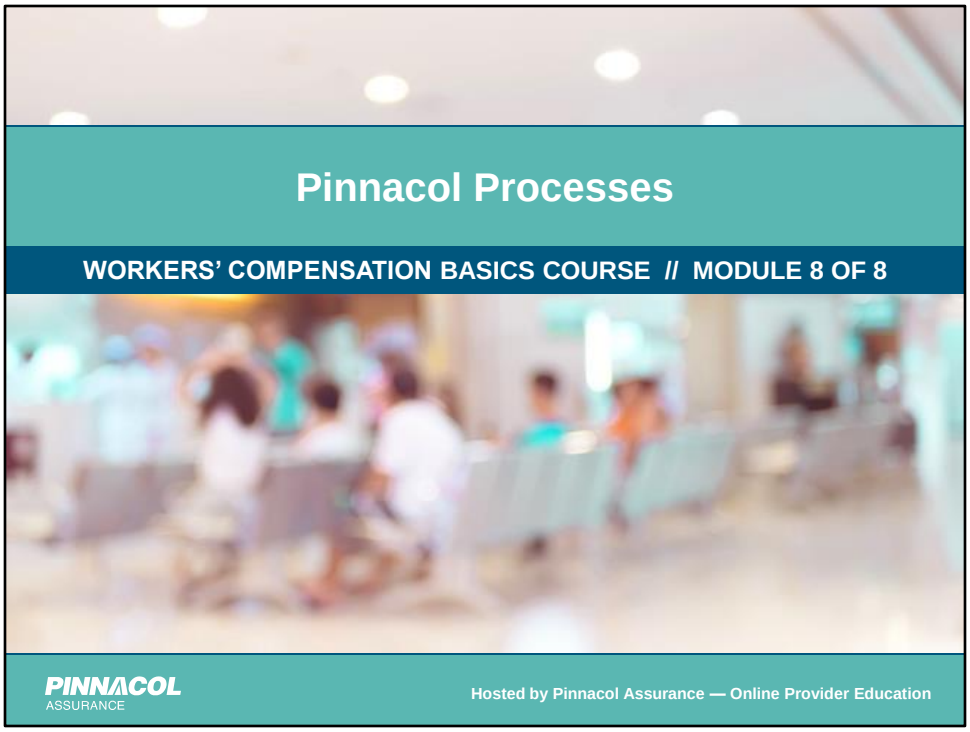
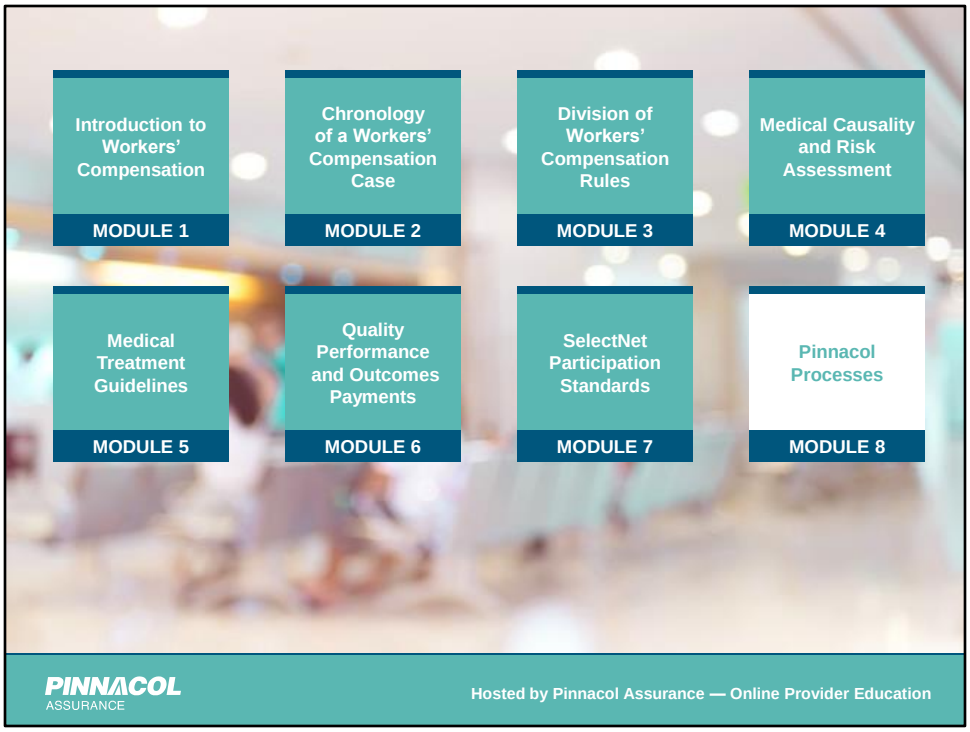


This module will review the processes that Pinnacol follows when managing workers' compensation claims.


Introduction to Workers' Compensation
MODULE 1
Chronology of a Workers' Compensation Case
MODULE 2
Division of Workers' Compensation Rules
MODULE 3
Medical Causality and Risk Assessment
MODULE 4
Medical Treatment Guidelines
MODULE 5
Quality Performance and Outcomes Payments
MODULE 6
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PINNACOL ASSURANCE
Hosted by Pinnacol Assurance — Online Provider Education

Authorizations

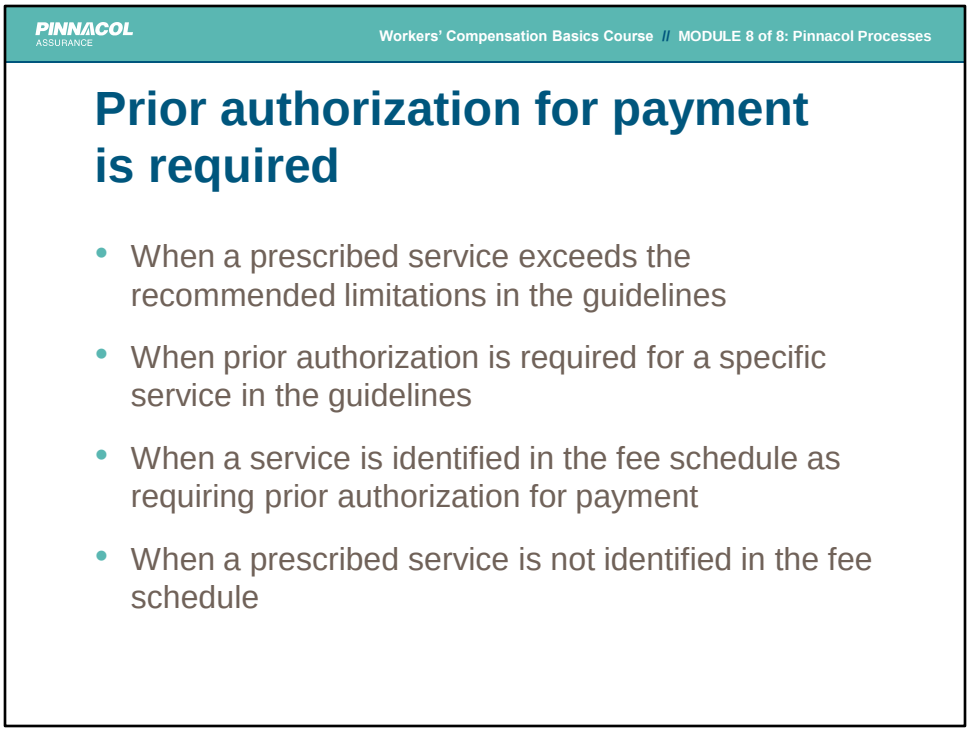
Prior authorization for payment is not necessary for diagnostic testing, in-network referrals or treatments when consistent with the Medical Treatment Guidelines issued by the Division of Workers' Compensation (DOWC).

Understanding when prior authorization for payment is needed will save you time.

Prior authorization is not necessary for diagnostic testing, in-network referrals or treatments when consistent with the Medical Treatment Guidelines issued by the DOWC.

Rule 16 is the reference for prior authorizations.

Consulting the guidelines will help you know when you can proceed with testing, referral and treatments without notifying Pinnacol or obtaining approvals.



- When a prescribed service exceeds the recommended limitations in the guidelines;
- When prior authorization is required for a specific service in the guidelines;
- When a service is identified in the fee schedule as requiring prior authorization for payment; and
- When a prescribed service is not identified in the fee schedule.

To ensure accurate and efficient claims management, we need to receive medical records and correspondence as soon as possible.

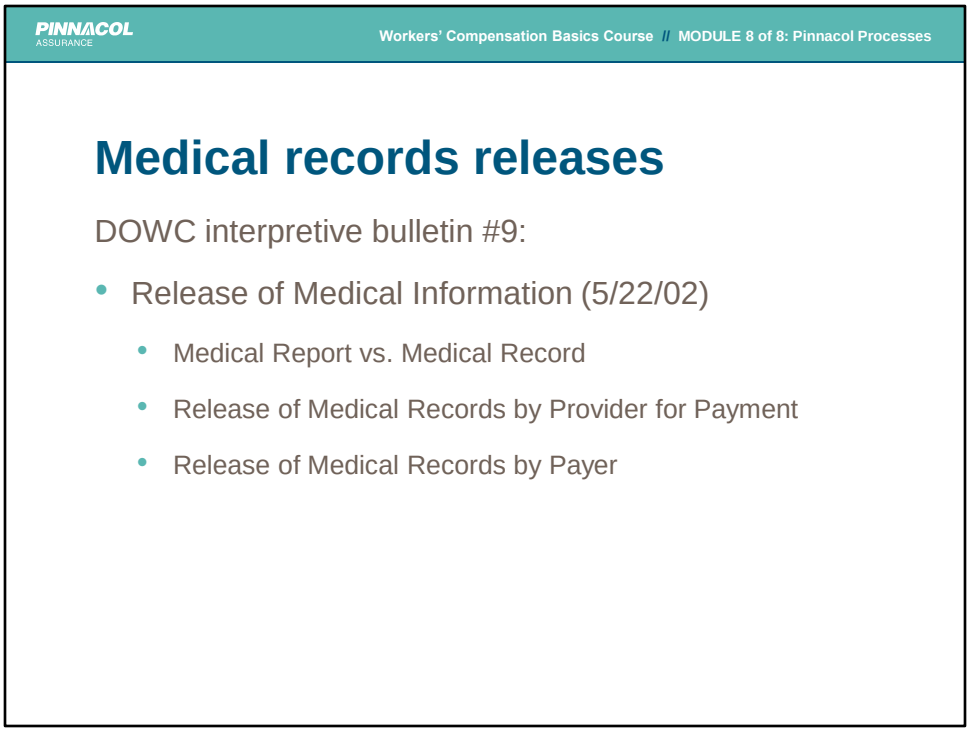
In addition, when it comes to workplace injuries, the Division of Workers' Compensation has strict requirements for the timely maintenance of medical records.

That's why it's so important for medical providers and Pinnacol to work in close partnership.

We urge you to send us every piece of paperwork related to your patients' medical care as soon as possible.

That includes correspondence, records, worksheets, and absolutely everything associated with the patient's treatment.

The medical records FAX number is 303.361.5910. Outside of metro Denver, you can use the toll-free number: 866.820.6134.

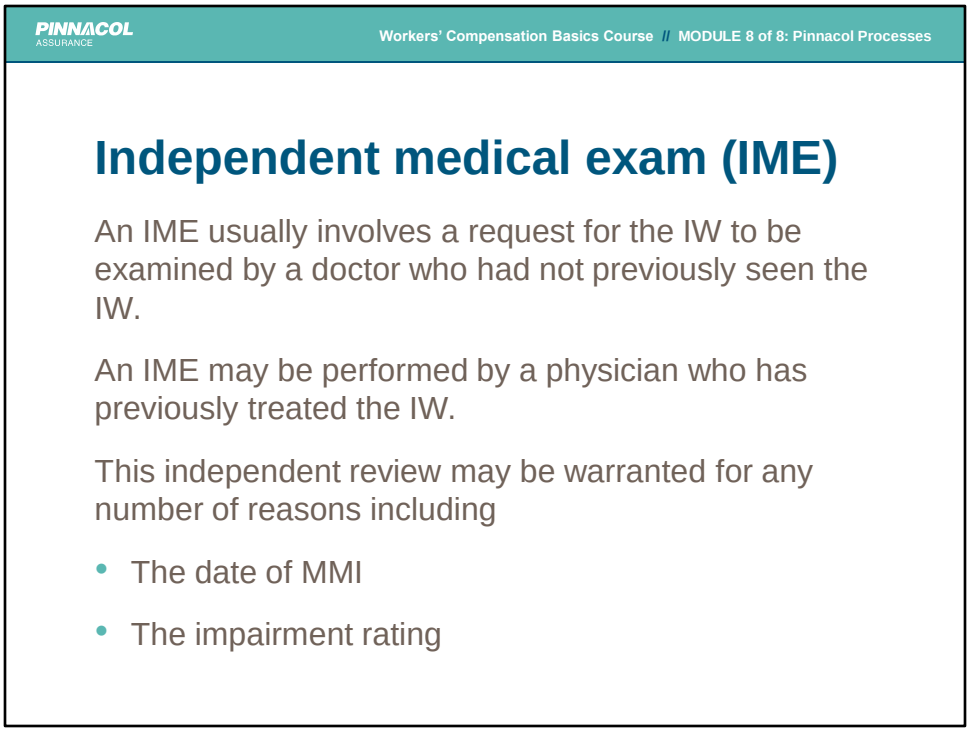


The DOWC interpretive bulletin number 9 (https://cdle.colorado.gov/medical-fee-schedule-directors-interpretive-bulletins) provides guidance on the release of medical records and protected health information.

It includes the DOWC Director's position on the exchange of medical records based on the statutory limited waiver of HIPAA regulations and workers' compensation case law.

The short bulletin from 2002 covers the release of medical information by the provider for payment and the releases by the payer.

A written release from the patient is not needed for the provider to send records to the payer.



An independent medical exam usually involves a request for the claimant to be examined by a doctor who had not previously seen the claimant.

However, the IME **can** also be performed by a physician who has previously treated the IW.

This independent review may be warranted for any number of reasons, such as opinions on maximum medical improvement or treatment modalities.

Division IME

If there is a dispute between the IW and the employer concerning the MMI date or the impairment rating provided by the ATP, and the parties wish to bring this dispute before a judge, the law requires the parties to obtain a DIME.

If there is a dispute between the injured workers and the employer concerning the MMI date or the impairment rating provided by the authorized treating physician and the parties wish to bring this dispute before a judge, the law requires the parties first obtain a DIME.

DIME

- Established to reduce litigation and to provide an alternative way to address disputes
- Performed by a Level II-accredited physician
- If parties cannot agree, the Division will select an examiner

Division IME's were established to reduce litigation and to provide an alternative way to address disputes involving MMI and impairment.

All DIME's are performed by Level II-accredited physicians.

If parties cannot agree upon a physician, the Division will select an examiner based on an application submitted by the party who objects to the ATP's rating or MMI determination.

Return to work

- PCP must respond within 2 business days of receipt of a modified duty or return to work request
- The letter must be signed only by a physician who has treated the IW.

If modified duty is not available, or the employer is unsure if a modified duty position is possible, contact Pinnacol claims for help.

Upon receipt of a modified duty or return to work request, the primary care physician must respond within two business days.

The letter must be signed only by a physician who has treated the worker.

If modified duty is not available or the employer is unsure if a modified duty position is possible, the Pinnacol claims rep can assist.

Provider communication

WC-164 or dictation should include

- IW's work status, including effective date
- Specific work restrictions
- The date of the IW's next scheduled appointment

For all forms, include the provider's name, clinic name, date of report, address, and phone number.

When addressing modified duty or full duty return to work, provider communication on a WC164 form, or dictation should include the IW's work status with the effective date, specific work restrictions and the date of the IW's next scheduled appointment if appropriate.

All forms should include the provider's name, clinic name, date of report, address and phone number.

Do not write "same as last visit," "as tolerated," "as needed," "per specialist report" or "continue with same work restrictions" as these instructions are difficult to interpret.

MMI

MMI is the point in time when

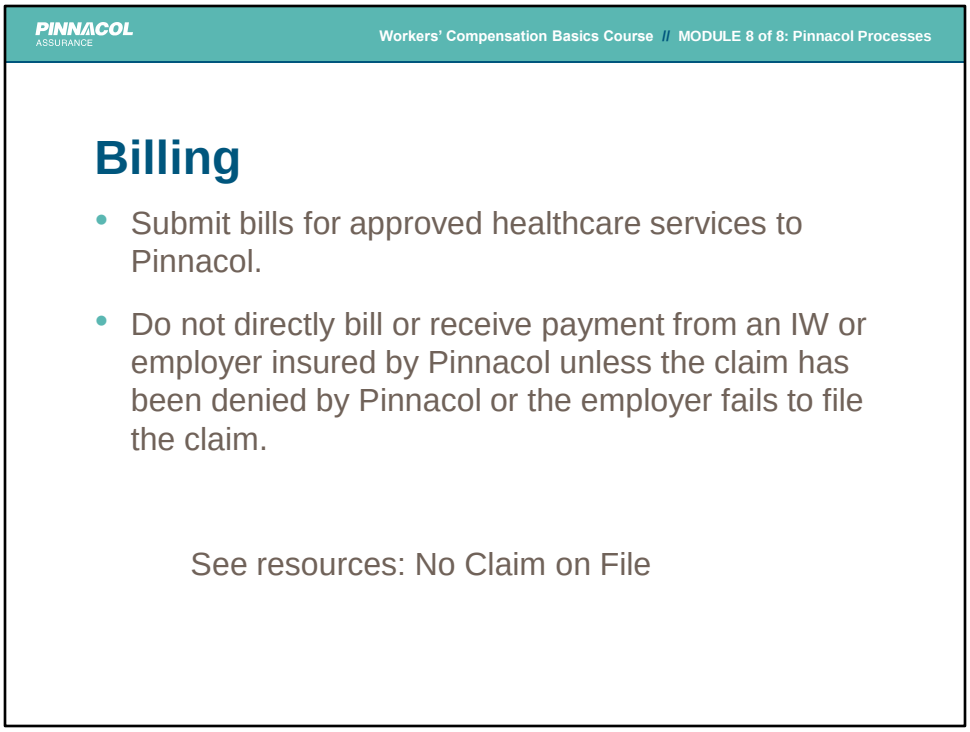
- Any impairment resulting from the injury has become stable, and
- No further treatment is reasonable expected to improve the condition

Treatment may be required after MMI in order to maintain functional status.

Maximum medical improvement is the point in time when the impairment resulting from the injury has become stable, and no further treatment is reasonable expected to improve the condition.

Some patients may require treatment after MMI to maintain their functional status.

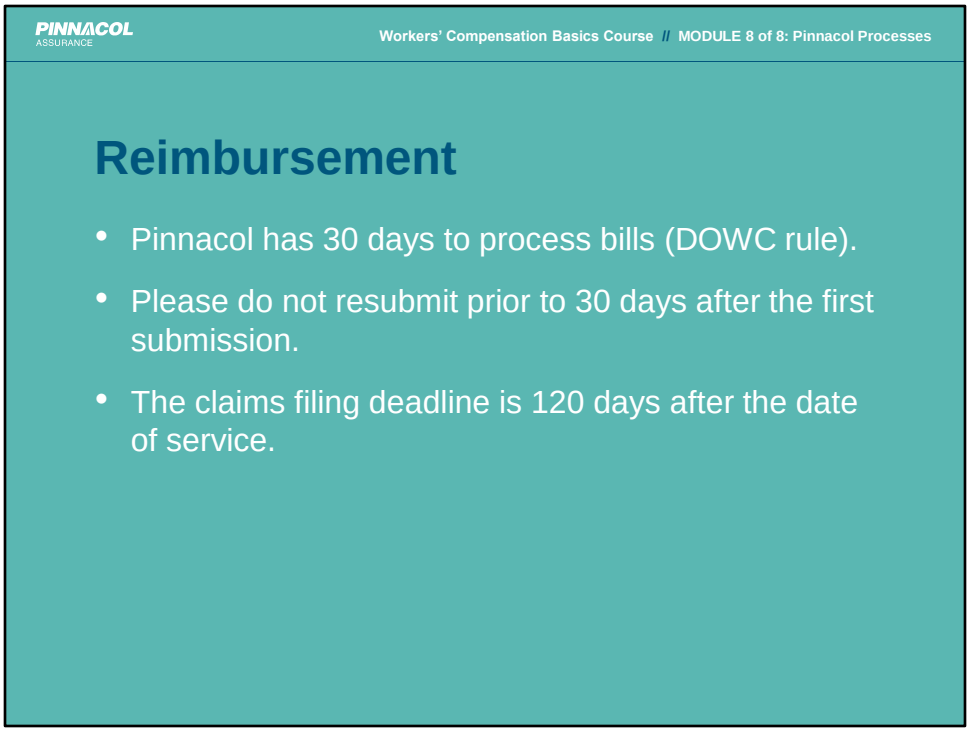
The provider should indicate whether continuing care is needed in the "maintenance care after MMI" section of the WC164 form.



Once liability has been determined, the provider should submit bills for approved health care services to Pinnacol.

The provider should not directly bill or receive payment from an injured worker or employer insured by Pinnacol unless the claim has been denied by Pinnacol.

Injured workers should not be billed. Please refer to the provided handout for situations when the employer has not filed the claim.

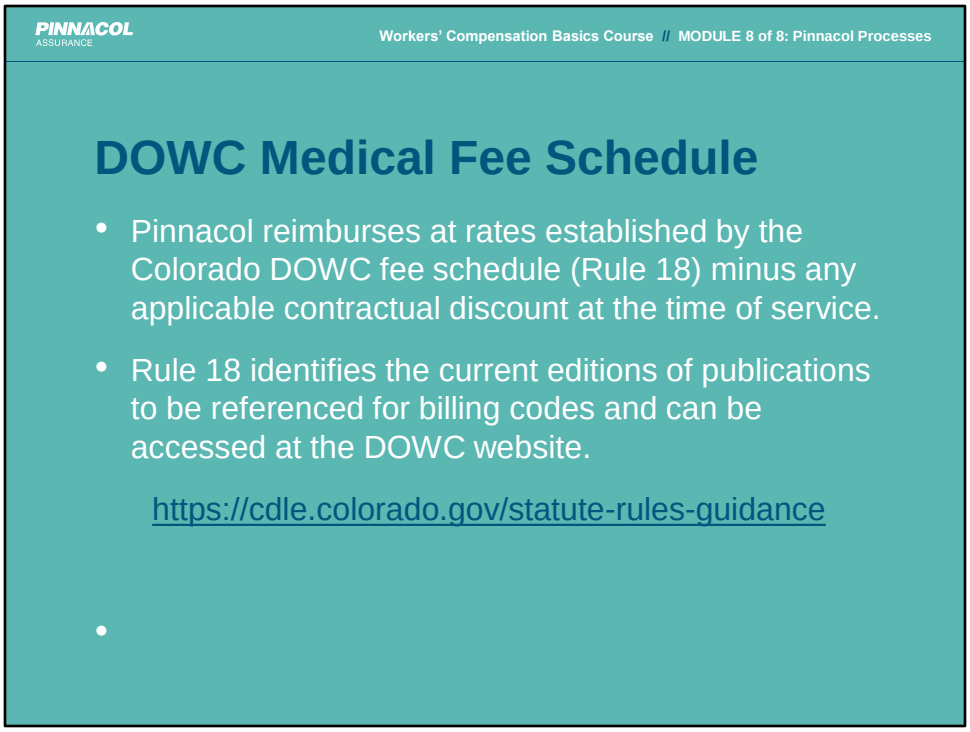


Based on the DOWC, Pinnacol has 30 days to process bills for payment. Please wait at least 30 days after the first submission to resubmit or investigate missing payments.

This causes duplicate bills and rework for Pinnacol and for the provider.

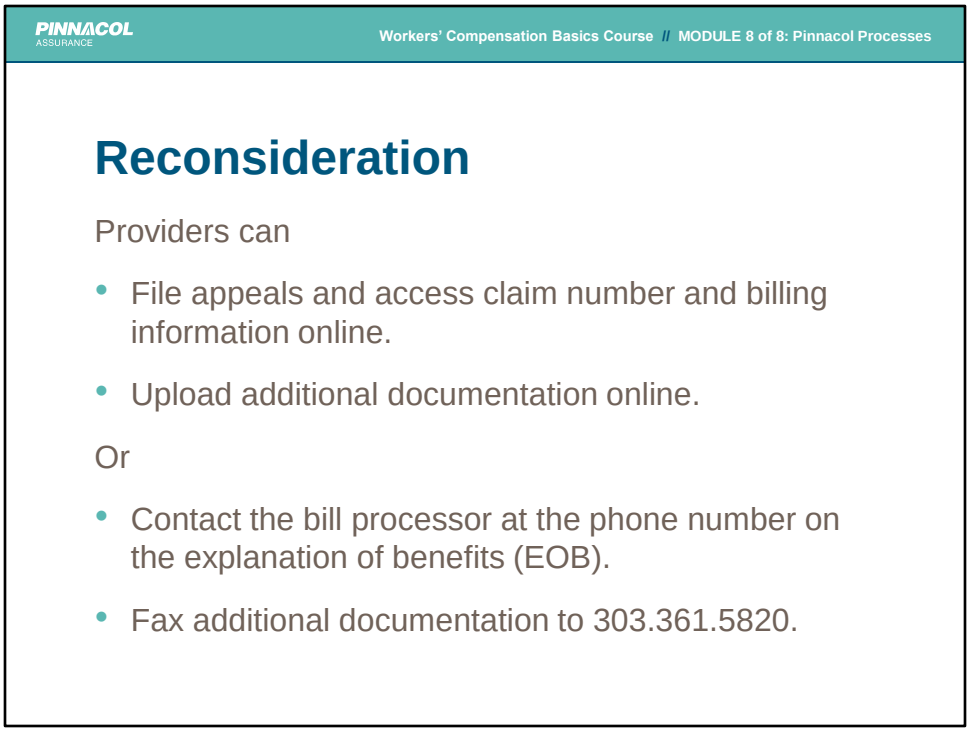
Providers should redact the Social Security number on all medical bills as the claim number serves as the worker's identifier.

The filing deadline for submitting bills is 120 days after the service has been performed.



Pinnacol reimburses at rates established by the Colorado DOWC fee schedule (in Rule 18), less any applicable contractual discount in effect at the time services are rendered.

Rule 18 identifies the current editions of publications to be referenced for billing codes and can be accessed at the DOWC website.



Appeals can be filed online and by phone or fax for all providers.

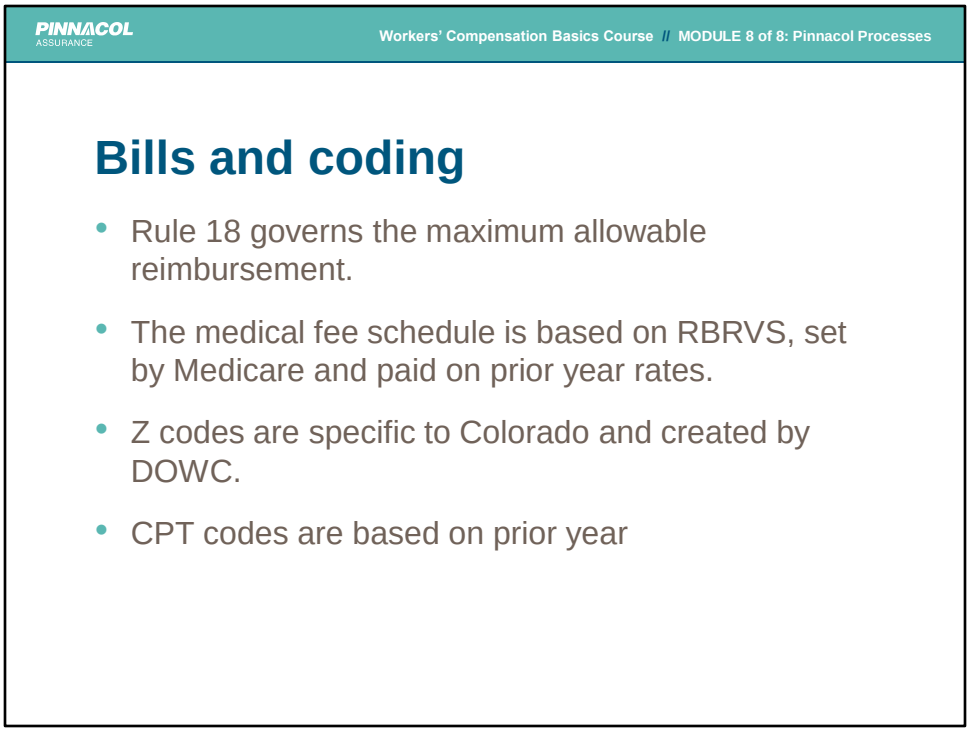
Providers can access the claim number and billing information online at Pinnacol.com.

A password is required to access claims and billing information, as is the claim number and the date of service.

The bill processor may be contacted directly at the phone number listed on the EOB.

Rebills requiring additional documentation can be faxed to 303.361.5820, Attention: Medical Payments Team

(This fax number should be used for rebills only).



Rule 18 governs the maximum allowable reimbursement on an RBRVS medical fee schedule, the basis of which is set by Medicare and paid on the prior year rates.

Z codes are specific only to Colorado and were created by the DOWC.

The CPT codes are based on the prior year and are updated annually.

Billing for initial visit

- Pinnacol will pay for reasonable and necessary medical treatment by the authorized treating physician and any referral providers.
- The IW does not pay a copay or deductible.

Pinnacol will pay for reasonable and necessary medical treatment by the authorized treating physician and any referrals.

The IW does not pay a copay or deductible.

For injuries with lost time (over three working shifts) and permanent medical impairment is anticipated,

Pinnacol must send a First Report of Injury form to DOWC.

Pinnacol has 20 days after the Division receives the notice of the claim to admit or deny compensability.

Payment for visits on denied claims

- Pinnacol is not responsible if liability is denied.
- Providers must check for eligibility and status.
- Pinnacol will pay for the initial visit if
  - Pinnacol arranges for the IW to be seen, or
  - The policyholder has sent the IW to their designated provider

Pinnacol is not responsible for any medical or indemnity (lost time) payments on any claim where liability has been denied.

Any payments by Pinnacol for medical services on denied claims should not be construed as an admission of liability.

It is the responsibility of the SelectNet provider to check claim eligibility and status.

Billing on a CMS1500

Box 31 — signature or printed name and professional credential of the provider who provided the service

Appendix C of the SN Manual provides "field by field" instructions for completing the CMS form (version 02-12).

Please note that in Box 31, Pinnacol requires the signature or printed name and professional credentials of the actual provider of the service.

Billing on a UB-04

Hospitals providers must complete all fields mandated by Medicare.

- Box 62 (insurance group #) — Pinnacol claim number
- Box 82 (attending physician) — physician, PA or NP name and license number

Hospitals and providers billing for dental services or procedures must complete all fields mandated by Medicare.

Box #62 (insurance group number) must contain Pinnacol's seven-digit claim number for the case being billed.

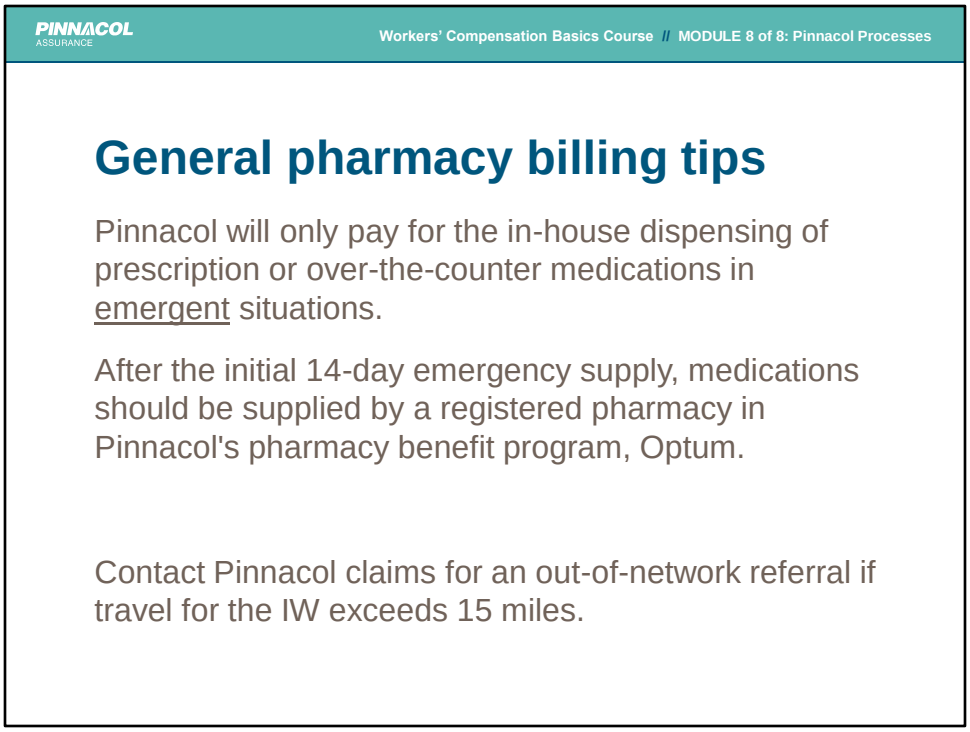
Box #82 (attending physician) must contain the physician's (or physician assistant's/nurse practitioner's) name and their Colorado license number.

Pinnacol has contracts with ancillary providers for outpatient physical, occupational and speech rehabilitation, orthotic and prosthetic care, durable medical equipment, and home health care.

The SelectNet directory lists the providers within the service area of the patient's work or home.

Billing for rehab and DME is based on contractual requirements and cannot be assumed to be paid directly to the physician or clinic without a contract.

If you are adding these services to your practice, please contact Pinnacol to update your contract and include this code set in your fee schedule.



Pinnacol will only pay for the in-house dispensing of prescription or over-the-counter medications in emergent situations.

Beyond the initial 14-day emergency supplies, for all other situations, medications should be supplied by a registered pharmacy in Pinnacol's pharmacy benefit program, Optum.

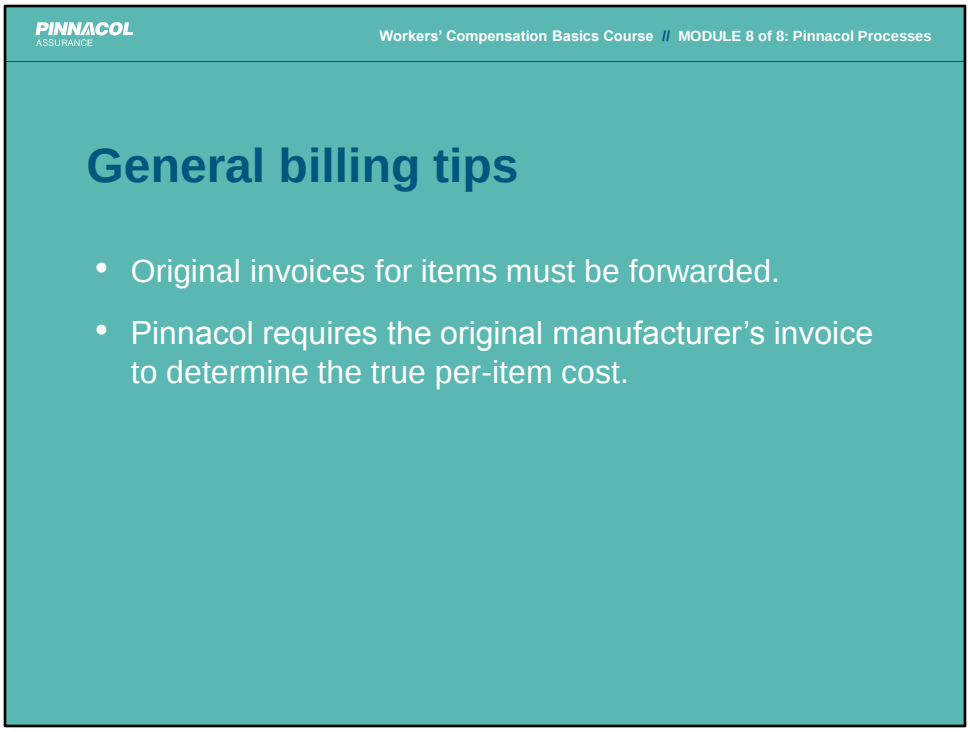
If this policy requires an IW travel more than 15 miles from the clinic for a participating pharmacy, please contact the Pinnacol claims team for an out-of-network referral.

Billing for modalities

Rule 18 limits payments to two different modalities per visit, per day, per discipline.

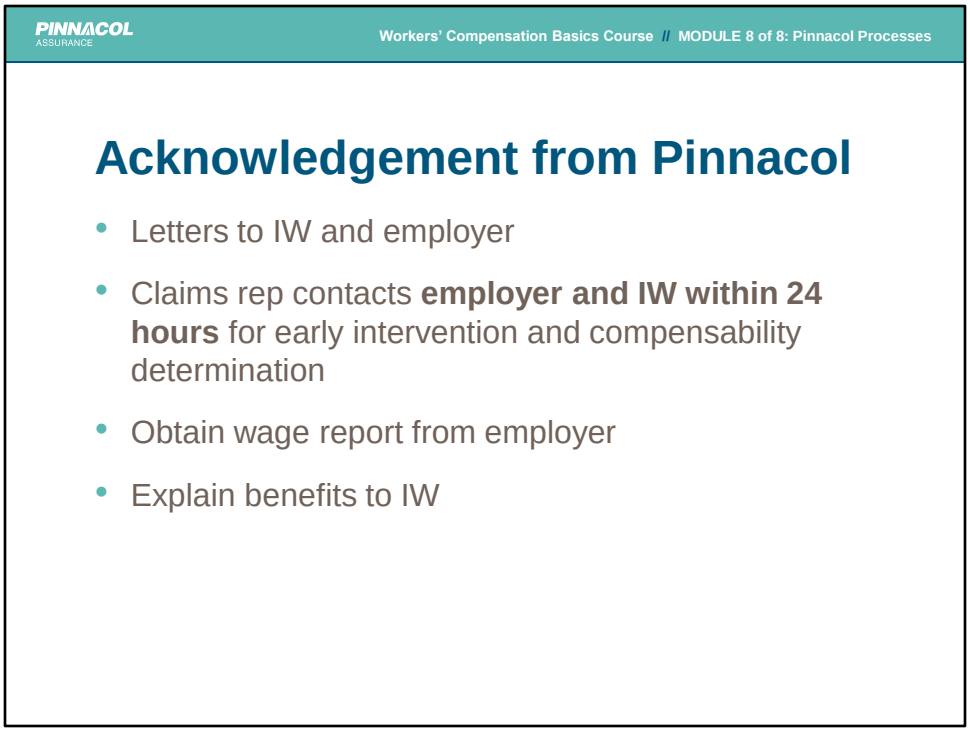
Rule 18 limits payments to two different modalities per visit, per day, per discipline.

As an example, in physical therapy, only guided exercise and e-stim will be paid on the same day.



Original invoices must be forwarded for individual items.

Pinnacol requires the original manufacturers' invoice to determine the true per item cost.



Letters are sent to the employee and the employer. Both are contacted within 24 hours.

Pinnacol will interview both for early intervention and the compensability determination.

The employer will be asked for a wage report, and the Pinnacol staff will explain the benefits to the injured worker.

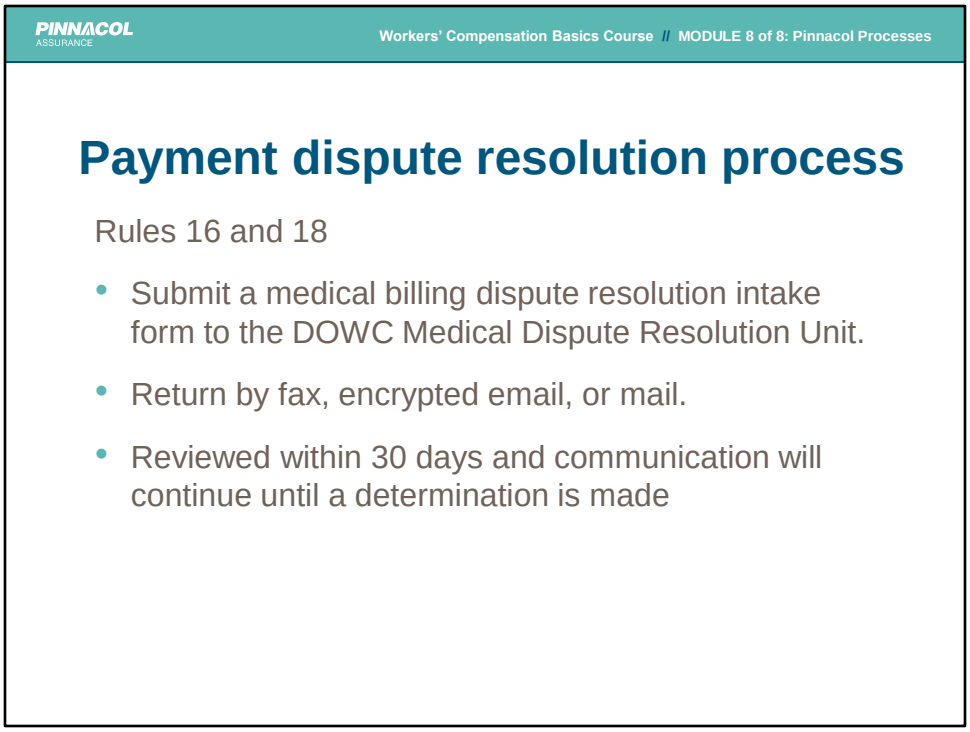
Claim investigation

- Medical history can help determine causality
- Apportionment for pre-existing conditions
- Sets baseline, conditions and expectations that effect the healing process

During the claim investigation, the medical history can help determine causality.

The provider's report will allow Pinnacol to apportion the claim for pre-existing conditions.

The first visit will determine the baseline and set the conditions and expectations with the patient that affect the healing process and the progress.



Rules 16 and 18 outline the dispute resolution process. The contesting payment process is outlined in Rule 16. If a payment dispute still exists or can't be contested because the other party has not satisfied the 30-day notice requirements, the parties should follow dispute resolution.

Either party may complete and submit a Medical Billing Dispute Resolution Intake Form to the Division's Medical Dispute Resolution Unit. The form provides guidance on what the Division will require to review your request. All applicable information should be provided at the time of the submission, including the supporting documentation outlined on the form. The form and documentation can be submitted to the Medical Policy Unit by fax, encrypted email, or mail.

Once a completed request has been received, the sender will receive a confirmation of receipt, and the case will be assigned to staff. The dispute will be reviewed to determine compliance with Rules 16 and 18. The result may be a Director's Order that cites the specific violation, and penalties may result if there is a failure to respond or cure the violations.

Resolution of disputes not pertaining to Rule violations will be facilitated by the medical policy unit to the extent possible. Typical cases are reviewed within 30 days, and parties will be notified in writing once the case is closed.

This concludes Module 8 on Pinnacol processes.

This is the last of the series on Workers' Compensation Overview.

Please proceed to evaluation and survey questions to obtain your certificate of continuing education.