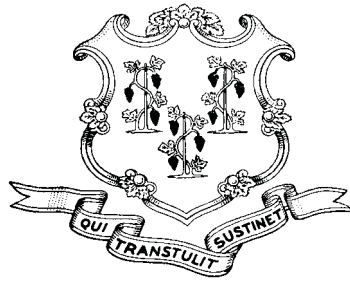


STATE OF CONNECTICUT
WORKERS' COMPENSATION COMMISSION



Payor and Medical Provider
Guidelines to Improve the
Coordination of
Medical Services

Effective Date: July 1, 2010

John A. Mastropietro, Chairman
Workers' Compensation Commission
21 Oak Street, Hartford, CT 06106
800.223.9675

Website: <http://wcc.state.ct.us>

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State of Connecticut
Workers' Compensation Commission
PAYOR AND MEDICAL PROVIDER GUIDELINES TO
IMPROVE THE COORDINATION OF MEDICAL SERVICES

INTRODUCTION

The purpose of the Workers' Compensation Act is to provide the timely and efficient delivery of monetary benefits and medical treatment to workers who have sustained injuries that are causally related to their employment. A properly administered workers' compensation claim serves the interests of both injured workers and employers. The benefit to the employee is the restoration of health and earning capacity that approximates pre-injury levels. The benefit to the employer is the return of a skilled and valuable employee and the avoidance of defending a personal injury civil suit. Conversely, a breakdown in the delivery process of workers' compensation benefits to injured workers results in confusion, needless delays, and the non-productive use of the Commission's hearing time; all of which fosters an acrimonious relationship among the injured worker, medical provider, employer, and insurance payor.

It is clear that the major impediment to the delivery of medical services is the lack of communication between the payors and providers. The consequence is a disproportionate dedication of the Commission's resources to hearings which are largely non-productive, i.e., they do not move the workers' compensation claim any closer to resolution. Communication, especially as it relates to medical treatment, is the key to ensuring the system's goals are achieved.

Timely decisions and effective communications provide an optimal outcome for all workers' compensation stakeholders. These are the goals that all should strive to achieve.

The Workers' Compensation Commission has identified some of the factors which contribute to the frustration experienced by all parties to a claim. This document outlines methods that will minimize such disruptions and assure compliance with Workers' Compensation laws and objectives.

The following guideline details the workers' compensation process and establishes a baseline of cooperation for the purpose of improving the delivery of medical services.

NOTE: ***Although these guidelines may appear to be repetitive in some areas, the redundancy is intended to underscore the common purpose among the various stakeholders.***

I. PAYOR RESPONSIBILITIES

While the Workers' Compensation Commission is aware that each payor may have its own method for the administration of claims, those methods must be consistent with the efficient administration of the workers' compensation system.

A. Payor Responsibilities Regarding Accepted Claims/Accepted Body Parts

1. Accepted Claims/Accepted Body Parts. An accepted claim is one:
 - a. which is acknowledged by all parties to have arisen out of and in the course of employment,
 - b. where an attending physician or facility has been identified for treatment, and
 - c. which is limited to accepted body parts.
2. Voluntary Agreements. The Workers' Compensation Act mandates that voluntary agreements be issued on all accepted lost-time cases. The voluntary agreement is a useful reference point for information pertaining to the claim.
3. Preapproval Unnecessary. In order to administer claims efficiently and promote timely and appropriate medical care, the following medical services, which are consistent with the established WCC Medical Protocols do not require preapproval. See <http://wcc.state.ct.us/download/acrobat/protocols.pdf>. This includes:
 - a. Routine or necessary office visits unless some aspect of the accepted claim/body part changes;
 - b. Routine prescriptions written by an authorized physician;
 - c. Physical therapy;
 - d. Chiropractic treatment;
 - e. X-rays; and
 - f. Pulmonary function tests.

The above items are in addition to and should not be considered a limitation of any other medical services/diagnostic and/or treatment that are already allowed by a payor's own internal protocols.

4. Prompt Communication. Telephone calls, faxes and e-mails should be returned within two (2) business days. This timely communication will promote the most positive outcome for all parties involved. However, it is important to recognize that medical providers are not always readily available by telephone, and therefore, may return telephone calls during lunch breaks and at the end of the business day. Parties should strive to reasonably accommodate each other whenever possible.
5. Written Extension of Authorization. The decision to approve or deny further diagnostics and/or treatment plans recommended by the authorized attending physician should be rendered by fax, email, or telephone within five (5) business days from the date of the request with a copy to the claimant. Written communication is preferred as opposed to telephone calls. Decisions cannot be made until the attending physician provides the appropriate information supporting the request.

Diagnostics and/or treatment plans that require written authorization include:

- a. Nerve conduction study/EMG;
- b. CT scan/MRI;
- c. Bone scan;
- d. Epidural steroid injection/Visco supplementation and facet injection;

- e. Additional physical therapy (beyond the established WCC Medical Protocols <http://wcc.state.ct.us/download/acrobat/protocols.pdf>);
- f. Surgery;
- g. Pain management;
- h. Physical medicine and rehabilitation;
- i. Additional chiropractic treatment (beyond the established WCC Medical Protocols <http://wcc.state.ct.us/download/acrobat/protocols.pdf>);
- j. Detoxification program;
- k. Diagnostic arthroscopy;
- l. Referral for second opinion/specialist; (see also Section IIA3 at page 6)
- m. Functional capacity evaluation.

Note: *It is ultimately the injured worker's decision to choose where a procedure/test will be conducted, subject to WCC-approved network restrictions.*

- 6. Denial of Authorization – Form 43. If the recommended diagnostic and/or treatment plan is denied, the payor should file a Workers' Compensation Commission Form 43 - Intention to Contest Employee's Right to Compensation Benefits (hereafter WCC Form 43) (<http://wcc.state.ct.us/download/acrobat/43.pdf>) and consider the need to:
 - a. Refer to peer review with a medical provider in a same or similar medical specialty; or
 - b. Refer to utilization review; or
 - c. Schedule a Respondent's Medical Exam (RME) with a medical provider in a same or similar medical specialty within 12 calendar days of payor's receipt of medical reports. If ordered:
 - i. The exam must be held within 60 calendar days after scheduled.
 - ii. If the examiner cannot meet the time constraints, another examiner should be selected unless the parties agree in writing to extend the deadline.
 - iii. The RME report is expected to be issued within 21 days of the exam.
 - iv. Prepayment of RMEs is prohibited. [Conn. Admin. Reg. Sec. 31-280-1(a)(6)]
 - v. It is recommended that the payor provide a pre-exam confirmation and reminder call to the injured worker and/or his/her representative at least forty eight (48) hours in advance to avoid "no show" fees.

B. Payor Responsibilities Regarding Contested Claims/Contested Treatment

- 1. Form 43. In order to contest a claim, a WCC Form 43 must be served on the Commissioner and the injured worker within 28 days of receipt of the written notice of claim. Copies of the Form 43 must be provided to the employer, medical provider, and injured worker's representative.
- 2. Payment Without Prejudice. The payor should consider authorizing an evaluation without prejudice if the injured worker does not have group health insurance. If the payor will be scheduling a respondent's medical exam (RME), it can consider paying indemnity and/or medical benefits without prejudice pending that exam.

3. Scheduling of RME. When scheduling an RME, it must be scheduled with a medical provider in a same or similar medical specialty within 12 calendar days from the payor's receipt of the medical reports.
 - a. The exam must be held within 60 calendar days after scheduled.
 - b. If the examiner cannot meet the time constraints, another examiner should be selected unless the parties agree in writing to extend the deadline.
 - c. The RME report is expected to be issued within 21 days of the exam.
 - d. Prepayment of RMEs is prohibited. [Conn. Admin. Reg. Sec. 31-280-1(a)(6)]
 - e. It is recommended that the payor provide a pre-exam confirmation and reminder call to the injured worker and/or his/her representative at least forty eight (48) hours in advance to avoid "no show" fees.

II. MEDICAL PROVIDER RESPONSIBILITIES

The role of the medical provider is pivotal to the overall success of a workers' compensation claim. Timely and appropriate treatment will allow the injured worker the best opportunity for the restoration of health and return to gainful employment.

A medical provider should be aware that the fee schedule set by the Workers' Compensation Commission is higher than that of most other payors. This higher payment is meant to accommodate the time that a provider must devote to the additional administrative requirements associated with workers' compensation claims.

During the life of a workers' compensation claim, a payor may challenge recommended treatment. This section will explain the medical provider's rights and responsibilities to improve the delivery of medical services and to minimize contests as to appropriate treatment.

A. Medical Provider Responsibilities Regarding Accepted Claims/Accepted Body Parts

1. Timely Decision on Treatment:
 - a. Injured workers have the right to see their authorized physician.
 - b. Preapproval is not required for these visits except when the prior visit occurred more than one year previously. In such cases, it is appropriate to request preapproval of an appointment for the accepted injured body part.
 - c. In order to administer claims efficiently and promote timely and appropriate medical care, certain medical services which are consistent with the established WCC Medical Protocols (<http://wcc.state.ct.us/download/acrobat/protocols.pdf>), do not require preapproval.

These medical services include:

- i. Routine or necessary office visits unless some aspect of the accepted claim/body part changes;
- ii. Routine prescriptions written by an authorized physician;
- iii. Physical therapy;

- iv. Chiropractic treatment;
- v. X-rays;
- vi. Pulmonary function test.

The above items are in addition to and should not be considered a limitation of any other medical services/diagnostic and/or treatment that are already allowed by a payor's own internal protocols.

2. Medical Reports:

The medical provider is required to furnish medical reports to the payor and the injured worker or his/her legal representative. C.G.S. Section 31-294f (b) requires reports must be provided within 30 days of completion. Hearings often cannot be conducted without these reports. Consequently, a medical provider may receive an urgent request for a report to be issued more quickly than stated above. Upon request, a Commissioner may determine whether this report warrants an additional fee to the physician.

The report should assess the injured worker's medical condition and define the recommended treatment. Medical providers are encouraged to meet this obligation by using the standard "SOAP" format ('Subjective/History; Objective/Findings; Assessment/Diagnosis; and Plan/Treatment') in the construction of their reports as follows:

a. History/Causal Relationship to Work

In the initial report, an accurate history is extremely important. It should include a detailed account of the injured worker's description of the events leading to the injury. The practitioner should offer an opinion as to whether the injury is work related.

b. Current Complaints and Physical Exam Findings

Reports must include a summary of all current complaints. Accuracy in recording treatment results, subjective complaints, and objective findings is imperative. If new symptoms arise which require additional treatment, the practitioner should provide medical justification for same and explain the relationship between the new symptoms and the original injury.

c. Diagnosis

Reports must reflect an ongoing diagnosis. Often this will be a continuation of the initial work-related diagnosis. The report should reflect the patient's current physical condition, i.e., whether improved, the same, or worse.

d. Treatment Plan or Tests

The physician should include a detailed recommendation of the treatment plan and any additional tests. The plan should include the medical necessity for these recommendations.

e. **Work Capacity and Restrictions**

It is important that during the examination the provider assess the patient by determining what activities the worker can perform. The medical provider should provide an updated status as to the injured worker's limitations/restrictions, if any.

The prompt forwarding of documentation of the above information is essential. The Commission appreciates the demands on the provider's time. Therefore, the Commission encourages the use of the "Medical and Work Status Form" as a tool to communicate promptly any changes in the patient's work status. The form is intended to be used as a supplement to routine progress reports.

3. **Referral/Second Opinion:**

The Workers' Compensation Act allows the injured worker to treat with a physician of his/her choice. On occasion, an attending physician may refer the injured worker to a specialist or to another doctor for a second opinion; which doctor is also the choice of the injured worker. As there may be institutional delays in getting such requests approved and/or for appointments to be scheduled, the attending physician should make this request as soon as it appears necessary, in writing, so as to avoid delay of the injured worker's treatment. Any such request or referral should include a medical basis/explanation.

4. **Communication:**

Having established that accurate and efficient communication among the parties is a necessity, medical providers must be available to answer reasonable inquiries. Telephone calls, faxes and e-mails should be returned within two (2) business days. This timely communication will promote the most positive outcome for all parties involved. However, it is important to recognize that medical providers are not always readily available by telephone and therefore may return telephone calls during lunch breaks and at the end of the business day. Parties should strive to reasonably accommodate each other whenever possible.

"Communication" includes the sharing of medical records. This generally requires a signed medical authorization from the injured worker. Providers are advised that workers' compensation medical records are excluded from HIPAA (Health Insurance Portability and Accountability Act). However, the parties are reminded that if a claim is determined not compensable, and therefore, not subject to the Workers' Compensation HIPAA exclusion, additional HIPAA-compliance measures may be required. For the purpose of expediency, a HIPAA-compliant medical authorization form is readily available on the Workers' Compensation Commission's website. Providers are urged to download this form when it would facilitate the exchange of medical information. See (<http://wcc.state.ct.us/download/acrobat/HIPAARel.pdf>).

Providers should furnish only the information that is requested and supported by the authorization. If there is a dispute as to what medical information must be provided, the parties can seek the opinion of a Workers' Compensation Commissioner.

5. Information Management:

Ready access to pertinent information is critical. An excessive number of claims are unduly delayed due to the submission of incomplete information. Maintaining a summary sheet in the injured worker's medical file with the following information readily available will facilitate the claims handling process:

- a. Employer/Employee Identification;
- b. Payor/Claim Number;
- c. Adjuster Name and Contact Information;
- d. Medical Care Plan;
- e. Requirements under the Plan.

Any questions concerning the existence of an approved Workers' Compensation Commission medical care plan or its requirements should be directed to the adjuster or its managed care designee; or when necessary, to the Commission.

B. Medical Provider Responsibilities Regarding Contested Claims/Contested Treatment

1. Possible Challenges to Treatment Recommendations. Payors may challenge a provider's recommendation for medical treatment for a variety of reasons, for example:

a. Untimely Claim/Notice of Injury

Treatment may be challenged because it is alleged that the injured worker failed to file a timely claim pursuant to statute or failed to provide notice to the employer in a timely fashion.

b. Compensability

Payors may claim the injury did not "arise out of and in the course of the employment" as required under the law, e.g., medical problem occurs at work but not as a result of work activity.

c. Subsequent Event

Payors may argue that an intervening event has altered and/or negated their responsibility to continue medical treatment. In this instance, the medical perspective on causation may differ from the legal concept of causation. Resolution usually requires a hearing before a Workers' Compensation Commissioner.

d. Reasonable or Necessary Treatment

Payors may challenge treatment as not reasonable or necessary. Workers' Compensation law requires that medical treatment must be "reasonable or necessary". Reasonable or necessary medical care is that which seeks to repair the damage to health caused by the injury even if the employee is unable to return to work.

i. *Palliative, not Curative.*

Generally, curative treatment is readily approved; however, palliative treatment is more scrutinized. Curative treatment is defined as that which “cures or alleviates an injured condition” and palliative treatment as that which “maintains but does not cure”. Input from the provider to justify the recommended treatment may be required.

There are instances where palliative treatment, while not curative, may still be appropriate treatment. If the parties fail to agree, a hearing before a Workers’ Compensation Commissioner should be requested.

2. Handling Medical Care in a Contested Case:

Providing medical care in a contested claim is challenging. However, once treatment has commenced, it is expected that the treatment will continue. The provider is normally informed of the contest through a WCC Form 43 or the utilization review process which should be forwarded by the payor. If the parties cannot resolve the dispute, a hearing should be requested before the Workers’ Compensation Commission.

A provider may be called upon to provide justification for the medical treatment suggested. In some cases, the provider may also be asked to comment on a Respondent’s Medical Exam (RME) report. This response may involve the request for a report, a deposition, or in very rare cases, live testimony before the Workers’ Compensation Commission.

a. *Payments for Medical Care in a Contested Case.*

In a contested case, the claimant still requires treatment but the issue of payment for same then arises. If the injured worker is covered by a group health insurance policy, C.G.S. Sec. 31-299a requires the group health insurer to pay for the injured worker’s medical treatment consistent with the provisions of the group health insurance contract.

The medical provider may submit billing to the group health insurance carrier during the contested period. The payor should issue a WCC Form 43 to facilitate this; see Section III herein. If the case is eventually accepted by the payor, or subsequently determined compensable by the Commission, the provider may resubmit billing to the workers’ compensation payor so as to receive the higher fees permitted under the Workers’ Compensation Official Practitioner Fee Schedule. If the provider chooses this option, it would then be necessary to reimburse the group health insurer.

Note: *During the pendency of a disputed claim, medical reports and/or opinions from providers may be necessary to resolve legal disputes concerning compensability. A provider may request a reasonable fee for these reports subject to approval by the Workers’ Compensation Commission. See “WCC Professional Guide for Attorneys, Physicians and Other Health Care Practitioners Guidelines for Cooperation” at <http://wcc.state.ct.us/download/acrobat/proguide.pdf>*

b. Unacceptable Methods of Payment in Contested Cases.

Attorneys are prohibited by the Rules of Professional Conduct from paying for treatment on behalf of the injured worker. Please be further advised that any representative signing a letter of protection for medical services must comply with ethical requirements established by the various statewide regulatory entities.

Note: *In the event that medical bills remain unpaid, a provider has the right to request a hearing before a Workers' Compensation Commissioner. Connecticut law prohibits legal action against the injured worker to collect outstanding balances [Conn. Admin. Reg. 31-279-9(e)].*

III. COMMUNICATION AND THE HEARING PROCESS

Too many hearings are generated by the lack of decision-making in the payor/provider relationship as it pertains to the approval/denial of medical benefits.

Workers' Compensation Commission regulations require that the parties attending hearings be vested with the authority to address at a minimum the issues enumerated on the hearing notice (Conn. Admin. Reg. Sec. 31-279-5).

In the event that pre-hearing discussions of the issue resolve the dispute, the Workers' Compensation Commission requires a WCC Hearing Cancellation (HC) Form (<http://wcc.state.ct.us/download/acrobat/hc.pdf>) to be completed and received by the Workers' Compensation Commission three (3) days prior to the scheduled hearing.

As previously discussed, circumstances sometimes arise that require the payor to issue a WCC Form 43. This should be issued within five (5) business days from the provider's request for medical treatment and should state the specific reason(s) for the denial of the treatment requested. When necessary, appropriate medical documentation should be attached to the WCC Form 43.

Once a WCC Form 43 is received, the injured worker/representative should contact the payor to discuss the reason for the denial. If the issue cannot be resolved and proceeds to a hearing, it is mandatory that the payor representative have authority to potentially resolve the noticed issue at the hearing. If the matter proceeds to a preformal hearing, and the authority of the hearing representative is insufficient to resolve the issues, an adjuster or appropriate representative should be available by telephone to assist in potentially resolving the noticed issue(s). The failure to provide authority at any hearing may result in sanctions/penalties at the discretion of the Commissioner. (Conn. Admin. Reg. Sec. 31-279-5).

Note: *Medical providers are again reminded that the failure to provide timely reports will seriously compromise the ability of the trial commissioner to resolve the issues noticed.*

IV. EX PARTE COMMUNICATIONS

Although communication facilitates the efficient processing of workers' compensation matters, the payor and the provider must avoid any effort to unduly influence decision-making. Allegations of this sort will necessitate additional hearings which will severely slow the process and may result in sanctions.

A. Communication with Attending Physicians

The injured worker and/or his/her representative are free to communicate ex parte with the attending physician. Communication between payor and the attending physician where such communication would involve unilateral disclosure or discussion of material information is not allowed. Communication should occur in writing with notification to all parties.

Payors, however, may request the physician to complete a work status form or other approved WCC form, or provide progress notes. Copies of this communication, as well as any responses from the physician, must be provided to the injured worker or his/her representative.

B. Communication with a Respondent's Examiner

Where a physician has performed an employer/respondent's medical exam, payor and/or respondent's counsel is free to communicate ex parte with that physician. Injured worker's counsel should not communicate ex parte with the respondent's examiner; communication with that physician should be coordinated through the respondents' representative.

C. Communication with Commissioner's Examiners

The Workers' Compensation Commissioner is vested with the authority to order a medical examination of the injured worker. Generally, a Commissioner's Examination is ordered when the opinions of the attending physician and respondent's examiner cannot be reconciled.

Where a physician has examined an injured worker at the request of the Workers' Compensation Commissioner, neither party is allowed to communicate ex parte with that physician. If the need arises for either party to communicate with the Commissioner's examiner, any inquiries or requests for information must be directed in writing to the Workers' Compensation Commissioner who will then refer it to the Commissioner's examiner if deemed appropriate. A copy of any such correspondence will be sent to all parties.

V. INJURED WORKERS

An injured worker must file a WCC Form 30C (Notice of Claim) to insure his/her statutory rights are protected *unless* a Voluntary Agreement has been approved by the Commissioner.

A. Timely Decisions and Communications

The objective of the Workers' Compensation Act is to provide timely and efficient medical treatment and indemnity benefits to a worker whose injury arises out of and in the course of employment. In most instances, medical services will be authorized without preapproval if a claim is accepted and the treatment is ordered by an authorized medical provider. (See Section IA: Payor Responsibility Regarding Accepted Claims).

However, circumstances may sometimes arise which will result in the denial of requested/recommended treatment. In these situations the injured worker should seek the assistance of the Commission as soon as possible to resolve the dispute and not delay the recommended treatment any longer than absolutely necessary.

The injured worker must also meet his/her responsibilities in order to assist their own recovery. Attending appointments and adhering to a provider's instructions is critical both for an optimal medical result and to protect benefits which may be available to the injured worker.

The following presents the injured workers' rights and obligations outlined under the Workers' Compensation Act for accepted and contested cases:

B. Accepted Claims

1. Occurrence of Injury. When an injury occurs, medical treatment will be approved if it is reasonable or necessary and arises as a result of the work-related injury. The employee must immediately notify the employer of the injury and the circumstances as to how it occurred. Employers will identify the treatment facility where the injured worker must report for the initial visit.
2. Appointments. The injured worker must attend all scheduled appointments and should obtain a written update of his/her current work status. In the event that an appointment is missed for valid reasons, the appointment must be rescheduled as quickly as possible. It should be understood that failure to keep appointments will impose additional delay of necessary treatment and could result in a suspension of benefits and/or sanctions per order of a Workers' Compensation Commissioner.
3. Choice of Physician. If further treatment is necessary, the injured worker may choose a provider from an existing approved workers' compensation network if one exists. If the employer does not have a provider network the injured worker may choose any provider in the state of Connecticut. On occasion, an attending physician may refer the injured worker to a specialist or to another doctor for a second opinion; which doctor is also the choice of the injured worker. Similarly, this choice also extends to any diagnostic testing or treatment facility.

4. Employer and/or Commissioner Medical Examinations. The law allows an injured worker to be examined by a medical provider chosen by the employer/insurer and/or the Commissioner. Attendance at these examinations is mandatory. It is the responsibility of the injured worker to appear at the scheduled time and to bring with them any radiographic studies, e.g., x-rays, MRIs, CT-Scans, etc. The examining physician is free to ask questions and the injured worker should answer them accurately. The employer/insurer will provide all other medical records. The employer/insurer is responsible for reimbursing mileage. If the injured worker is not otherwise receiving or eligible to receive weekly compensation, the employer/insurer is also responsible for paying time lost from work to attend the examination.

5. Contents of Medical Reports/History Given to the Physician. The injured worker should request a copy of medical reports be sent to them. It is recommended that the injured worker review the medical report to ensure accuracy. It is important that the history taken by the physician accurately reflects the circumstances surrounding the injury. In addition, the injured worker should make certain that all of the body parts involved are accurately identified in the report.

C. Contested Claims

A contested workers' compensation claim generates uncertainty for everyone and potential anxiety for the injured worker. Claims can be contested for a variety of reasons. The injured worker is advised to make every effort to resolve any disputes directly with the employer/insurer or its representative. If unsuccessful, the injured worker should request a hearing before the Workers' Compensation Commission. Some examples of reasons why claims might be contested include:

1. Injuries alleged not to have arisen out of and in the course of employment.
2. Claims that are not filed in a timely fashion or reported to the employer in a timely manner.
3. Prior/subsequent injury to the same body part claimed.
4. Whether the medical treatment suggested is reasonable or necessary.

D. Approach to Take When a Claim is Contested

1. Informal Discussion/Request for Hearing. To address the reasons for the denial of a claim, the injured worker should contact the employer/insurer first to determine if further information/documentation is necessary. If the parties are unable to resolve the dispute, the injured worker should contact the Workers' Compensation Commission for information and/or request a hearing before a Commissioner. The injured worker may retain an attorney if so desired.

2. Use of Group Health Insurance/Payment Without Prejudice. If the injured worker requires treatment during the time the case is being investigated/contested, the worker may utilize group health insurance, Medicare, Medicaid, and/or Veteran's benefits to obtain the necessary medical treatment. Workers' Compensation law allows for these payments to be made while the contest is being adjudicated. If the decision is in favor of the injured worker, the workers' compensation insurer is required to reimburse any other insurer who has paid for

treatment in the interim. The injured worker may have paid certain out-of-pocket expenses, e.g., co-pays, mileage, etc. A record of these payments should be kept so that reimbursement can be made should compensability of the claim be established.

Note: *There may be other public sources of financial assistance available to the injured worker to help sustain them while the contest is being adjudicated. The Workers' Compensation Commission may be consulted for information.*

VI. SUMMARY

All participants in the workers' compensation system must make their best effort to communicate with each other to meet the goals of the Workers' Compensation Act. The hearing process should not be initiated by failure to communicate but rather by the inability to resolve disputes after good faith efforts prove unsuccessful.

All parties in a workers' compensation matter have rights and obligations. For example, just as an injured worker must give complete and accurate information to physicians, so must physicians accurately record the information given and issue reports promptly.

In addition, payors must make decisions in a timely fashion that will allow a case to proceed as quickly as possible to resolve any outstanding issues.

Finally, once the hearing process has started, participants should be vested with the authority that will allow issues to be resolved or litigated.