2016 Pinnacol Assurance and ***SelectNet*** Provider Manual

Contents

Pinnacol Assurance and ***SelectNet***

Section 1

Introduction

Welcome to ***SelectNet,*** Pinnacol Assurance's preferred provider network dedicated to providing optimal medical care for injured workers in Colorado. The key to success in any working relationship is good communication. The purposes of this provider manual are:

- To provide information about Pinnacol and the Workers' Compensation Act of Colorado as it pertains to medical providers.
- To define key requirements and responsibilities of ***SelectNet*** providers.
- To define Pinnacol's responsibilities in working with ***SelectNet*** providers to serve the needs of injured workers and their employers.

About Pinnacol

Pinnacol is Colorado's choice for workers' compensation insurance, with more than 56,000 policyholders throughout the state. Our mission is to provide an assured source of workers' compensation insurance to Colorado employers and their greatest asset — their employees.

Pinnacol is a values-based organization. These shared values include:

- **Integrity** – Being honest and direct, and holding ourselves to a high standard in everything we do.
- **Excellence** – Striving to exceed our customer's expectations at every point of contact.
- **Accountability** – Taking responsibility for our decisions and actions.
- **Teamwork** – Working together for our customers' benefit.
- **Innovation** – Continuously pursuing new ways to do things better.

At Pinnacol, our unique structure focuses multidisciplinary teams of employees on specific customer groups, enabling us to work seamlessly for the benefit of our customers. Each team includes underwriters, auditors, claims representatives, nurse case managers, and safety services and return-to-work specialists. Insurance fraud investigation and legal services are also available to our teams.

SelectNet

SelectNet is Pinnacol's integrated, preferred provider network encompassing primary, secondary and ancillary medical services. The goal of ***SelectNet*** is to provide the injured worker with the right amount of care at the right time, and to safely return him or her to work as quickly as possible.

The network uses a gatekeeper physician model for the delivery of medical services.

Integrated services available within the network include:

- Primary care providers;
- Specialist physicians;
- Psychologists;
- Midlevel practitioners;
- Social workers;
- Physical, occupational and speech therapy;
- Orthotics and prosthetics;
- Home health care;
- Durable medical equipment;
- Podiatry;
- Massage therapy;
- Acupuncture;
- Chiropractic care;
- Urgent care clinics;
- Inpatient and outpatient hospitals and facilities;
- Skilled nursing facilities; and
- Pharmacies.

Regulatory Requirements

Section 2

Overview

The Workers' Compensation Act of Colorado (the Act) is part of the Colorado Revised Statutes (C.R.S.). The Act was adopted by the Colorado General Assembly to ensure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation. The Colorado workers' compensation system has ensured that injured workers receive appropriate care since 1915.

The Colorado Department of Labor and Employment, Division of Workers' Compensation (DOWC) formulates Rules of Procedure for workers' compensation. These Rules of Procedure give operational interpretation and structure to the statutory language that governs workers' compensation in Colorado. Workers' compensation laws and procedures are different in each state, and there is no direct federal oversight of Colorado's state program.

To obtain a copy of the Act, visit: www.colorado.gov/pacific/cdle/workers-compensation-act

To obtain a copy of the Colorado Workers' Compensation Rules of Procedure, visit: www.colorado.gov/pacific/cdle/rules-procedure-2

When Is a Claim Compensable?

Three legal conditions must exist for an injury to be compensable:

1. At the time of the injury, both the employer and the injured worker must be subject to the Act;
2. At the time of the injury, the injured worker must be performing a service arising out of, and in the course of the injured worker's employment;
3. The injury must be proximately caused by an injury or occupational disease arising out of, and in the course of the injured worker's employment, and it must not be intentionally self-inflicted.

Claims for Mental Impairment without Physical Injury

The Act provides compensation for claims resulting from work-related stress and from mental impairment caused by work-related physical injury or occupational disease. The Colorado Legislature, recognizing that claims for mental impairment may be filed easily and may be difficult to defend, has imposed additional requirements that must be proven by the injured worker to bring a successful "stress claim."

Four conditions must exist for a mental impairment claim to be supported:

1. The claim must be proven by evidence supported by the testimony of a licensed physician or psychologist;
2. The basis of mental impairment must have arisen primarily from the injured worker's occupation and place of employment;
3. The claim may not be based, in whole or in part, on facts and circumstances common to all fields of employment;
4. As stated in the Act, "The mental impairment which is the basis of the claim must

be, in and of itself, either sufficient to render the employee temporarily or permanently disabled from pursuing the occupation from which the claim arose or to require medical or psychological treatment."

Occupational Disease Claims

The following conditions are necessary to support an occupational disease claim:

1. The last employer and/or insurer in which the injured worker was exposed are exclusively liable for compensation benefits if the last injurious exposure (i.e., exposure to hazards that would cause the condition if continued) caused a significant and permanent aggravation;
2. The employer and/or insurer, at the time that medical expenses are incurred, are liable for those medical benefits (i.e., the insurer or self-insured employer at the time of the employment that caused the need for medical treatment is liable for such expenses).

Injury Reporting and Time Frames

Colorado law mandates specific time frames for employers, employees, payers and claims representatives for the administrative management of workers' compensation claims. Refer to the DOWC for the current requirements for:

- Injured workers to report injuries to their employers
- Injured workers to report occupational diseases to their employers
- Employers to report to their insurance carriers
- The maximum time limit to file a claim
- Reopening a claim

Independent Medical Examinations

Sometimes during the course of a claim, there is a need to clarify the medical/legal status of an injured worker through an independent medical examination (IME). There are two types of IMEs. One is administered through the DOWC and is called a "Division IME (DIME)." The other type of IME is not administered through the DOWC and is called a "non-Division IME."

Division IMEs (DIME)

These examinations can be used to settle issues of maximum medical improvement (MMI) and impairment ratings (IR). An injured worker or Pinnacol can request a Division IME, but only at certain times during the course of a claim.

Level II-accredited physicians who serve on the DOWC's IME panel perform all Division IMEs. The findings are binding on all parties and can be overturned only by "clear and convincing evidence." Providers who perform Division IMEs are directed by the DOWC and are performed independently of any contract between Pinnacol and a provider. Division IMEs are paid without PPO discount at the rate set by the DOWC and are generally paid by the requesting party.

Non-Division IMEs

A non-Division IME is an examination performed independently of the DOWC's IME procedures. These examinations are used to help settle causality or other medical and/or legal issues. Typically, the payer requests this type of IME and has chosen the examiner. The findings of non-Division IMEs are not binding and will be paid at the appropriate statutory rate. Questions regarding a non-Division IME should be directed to the requesting party.

Physicians' Accreditation

This is a state mandated educational program to instruct providers on their role in workers' compensation and the administrative and legal requirements pertaining to the treatment of injured workers. There are two types of accreditation: Level I and Level II.

Level I Accreditation

Level I is available to chiropractors, dentists, podiatrists and physicians who do not perform impairment ratings. Under Colorado law, Level I accredited physicians are not allowed to provide impairment ratings with the exception of determining that no impairment exists. Additionally, chiropractors are limited in the nature of treatment they can provide to patients, unless they are Level I accredited.

The Level I course is also available for mid-level providers (physician assistants, nurse practitioners, physical therapists and occupational therapists) through the DOWC. Beginning Aug. 10, 2016, physician assistants have the ability to become Level 1 accredited.

Level II Accreditation

Level II accreditation was established under Colorado law for providers who perform impairment evaluations, in addition to providing care to injured workers. There are two categories of Level II accreditation in Colorado: full and limited. Full accreditation allows a provider to perform impairment ratings for the entire body, while limited accreditation (available only to specialists) allows impairment ratings of limited body systems only.

Accreditation is valid for three years with an option to renew. Information about Level I and II accreditation programs can be obtained by calling the DOWC at 303.318.8763, or by accessing the DOWC website.

Provider Responsibilities and Case Management

Section 3

Introduction

Case management means different things in different settings. In a group health setting, case management is typically focused on the process of evaluating, planning, coordinating, facilitating and monitoring treatment alternatives and services essential to meeting an individual's health care needs.

In occupational medicine, effective case management occurs when physicians perform (or oversee) specific functions associated to the administrative, occupational, medical and legal issues, thus ensuring the injured worker receives appropriate, timely and cost-effective care. Those functions are identified in the following sections.

SelectNet Case Management

In ***SelectNet,*** the primary care provider (PCP), as the case manager, fulfills a multifaceted role. Typically the functions associated with case management of an occupational injury are:

- Assessing causality;
- Managing disability;
- Educating the injured worker;
- Determining physical work restrictions;
- Communicating with all parties;
- Initiating and managing referrals for specialty care;
- Medical management;
- Maintaining the injured worker's medical record;
- Determining Maximum Medical Improvement (MMI);
- Determining permanent impairment; and
- Discharging the injured worker from care.

The PCP may delegate certain tasks associated with some of these functions. For instance, effective case management generally requires at least one case coordinator and administrative support at the clinic level to assist the PCP with disability management, educating the injured worker, communication and scheduling. Under some circumstances, the PCP may request a ***SelectNet*** specialist to do the permanent impairment evaluation, while the PCP retains the role of case manager.

Occasionally, the needs of the injured worker are met best by transferring all case management duties from the PCP to a ***SelectNet*** specialist. In order for this to occur, the specialist must agree to accept the duties of case manager.

Regardless of who is ultimately responsible for performing the role of case manager, network participants are expected to comply with the specific participation standards associated with each component of case management, which is explained in the following

sections. Likewise, network PCPs are required to comply with Pinnacol's utilization management program, which is explained in Section 4 – Utilization Management.

Assessing Causality

There is a greater emphasis on causation in workers' compensation claims than in other areas of medical practice. Because the injured worker's employer is liable for compensation and benefits only for work-related injuries, disputes sometimes arise concerning the initial cause of the condition for which treatment is sought. Even if liability for the injury is admitted at the outset, there may still be a question later in the course of the claim concerning which physical ailments resulted from the work-related injury.

The question of whether an injury is compensable is an administrative one, decided by either a claims representative or an administrative law judge. The determination of compensability always involves an initial causality assessment to ensure that the condition for which treatment is sought was caused by some event or exposure occurring on the job.

Usually the causal connection between the on-the-job accident or exposure and the need for medical treatment is obvious. However, in some cases the compensability determination depends on the PCP's causality assessment. In cases in which the initial causality assessment requires a complex diagnostic workup, the PCP should call the claims representative to discuss a diagnostic strategy.

The necessary causal connection between the worker's medical condition and an event (or exposure) at work must be established to a reasonable degree of medical probability. This means there is greater than 50 percent likelihood that the medical condition was caused by the employee's job. If, in the PCP's opinion, the likelihood is 50 percent or less, the causal connection is then only possible rather than probable, and the medical condition cannot be properly ascribed to the employee's work.

The initial causality determination requires an assessment of medical probability. It is necessary that all of the following requirements be satisfied:

- An on-the-job event or occupational exposure took place;
- The injured worker has been properly diagnosed with an injury or disease;
- The on-the-job event or occupational exposure was sufficient to have caused the injury or disease; and
- It is medically probable that the on-the-job event or occupational exposure caused the injury or disease.

The cause of injury and injury diagnosis must be connected and the PCP should document that the injury is medically probable, rather than merely possible. No number of possible causes may be added together to create a probable cause.

Unless a causal factor has an immediate and visible effect on the worker, relating causation to a work factor requires reasonable epidemiological evidence for the association. Temporal association alone is not sufficient.

In making the initial causality assessment, the PCP should evaluate all information relevant to the diagnosis, including but not limited to:

- The injured worker's account of the accident or exposure;
- The worker's job duties;
- Exposure to hazards on the job; the worker's activities off the job;
- A complete medical history;
- All medical findings;
- Past medical records, if available;
- Results of any tests or other diagnostic procedures;
- Results of any occupational, environmental or industrial testing surveys; and
- Additional information from Pinnacol or the injured worker's employer.

The PCP must then determine whether a workplace factor is:

- The only cause;
- One of several contributing causes; or
- One of several possible causes, any of which could independently produce the condition.

If the PCP cannot assert that an accident or exposure on the job probably caused the need for medical treatment, the reasons for that opinion should be documented.

The causality assessment may also be important in cases in which an injured worker has aggravated a pre-existing condition, either temporarily or permanently. A temporary aggravation occurs when the natural course of a pre-existing condition is worsened temporarily, but the injured worker will eventually recover to the status that would have existed without the aggravation. A permanent aggravation occurs when the natural course of a pre-existing condition is worsened permanently, so that the injured worker will never recover the status that would have existed without the aggravation.

In either case, it is important to identify pre-existing conditions, the nature of the aggravation and the symptoms, signs or pathology attributable to the pre-existing conditions and to the work-related aggravation. If possible, the percentage of the employee's condition attributable to the pre-existing condition and to the aggravation should be identified. A PCP's statements concerning these questions must be expressed to a reasonable degree of medical probability.

When there is an aggravation or a recurrence of symptoms following a work-related injury, the PCP must determine whether the symptoms are a continuation of the original injury or a separate new injury, which may or may not be work-related.

Causality must also be assessed in instances in which a subsequent medical condition develops in conjunction with a work-related injury. If this occurs, the PCP must decide whether this new condition is causally related to the original injury, or if it is a new medical condition unrelated to the work injury. Once again, the subsequent condition must meet

the standards of medical probability. The PCP should document these findings as part of the injured worker's medical record and provide the information to Pinnacol's claims team.

The causality assessment may also be important at the close of the claim, when the authorized treating PCP normally evaluates the injured worker for permanent impairment. Generally, an employer is liable for compensation only for impairment actually caused by the work-related accident. The law relating to the rating of permanent impairment distinguishes between apportionment of impairment and a causation analysis designed to identify the impairment caused by the work-related accident. In order to ensure that a worker is properly compensated for the impairment caused by the work-related injury the PCP is to clearly identify the causes of any impairment present, based on objective evidence.

Finally, an assessment of the causative factors may be important in cases in which a worker has sustained an occupational disease, rather than an injury. An injury is traceable to one specific time, place and occurrence, while an occupational disease can occur from exposure to a hazard over a period of time that results in the condition. It may be that a particular hazard to which the injured worker was exposed worsened a pre-existing condition to cause the ultimate disease or disability. It also may be important to identify whether the injured worker's occupation was the sole source of the disease or disability, or whether the injured worker was exposed to the same or similar hazards off the job. As with the case of aggravations, an opinion expressed in terms of the percentages of the respective exposures is most useful when rendered in terms of medical probability.

Managing Disability

In workers' compensation, disability management means minimizing the adverse effects of an injury. By staying on the job or returning to modified duty, workers are more likely to recover quickly and sustain less permanent physical impairment than workers who are off work for an extended period of time. Maintaining a normal work routine contributes to financial stability and mental well-being, and is beneficial to social relationships, both at work and at home. By resuming a normal life, workers avoid assuming the role of a sick or disabled person.

After an on-the-job injury, there are several possible occupational outcomes during the course of treatment:

- Return to full duty at the pre-injury job;
- Return to modified duty, progressing toward full duty at the pre-injury job;
- Return to modified duty, progressing toward ultimate change to a different job; and
- Off-duty status.

The majority of Pinnacol claims are medical only or non-lost-time claims, meaning the injured worker misses fewer than three work shifts. The remainders of claims are lost-time claims that result from the worker missing more than three work shifts because of the injury. In most lost-time claims, physical restrictions can be determined by the PCP, which allows the worker to return to modified duty.

When an injured worker is unable to return to full duty or in a modified capacity, the PCP should still provide the injured worker and the claims management team a list of current restrictions that give the injured worker guidelines for acceptable activities outside of work. These restrictions help to prevent exacerbation of the injury.

The PCP is strongly encouraged to contact the appropriate Pinnacol claims representative when there are difficulties returning a worker to the job. Examples could include a worker who dislikes his job and does not want to return to work or a worker who does not believe his employer will provide modified duty. Each claims representative at Pinnacol has access to a return-to-work specialist who works directly with employers to assist them in providing modified duty in difficult employment situations. Providers can reach the Pinnacol Return to Work specialist at 303-361-4798.

It is extremely important that the PCP define specific restrictions rather than simply defining work status. The use of ambiguous or vague descriptors, such as “as tolerated,” “same as before,” “no change,” “see specialist report,” etc., are not adequate to set work restrictions.

In the absence of specific restrictions, the claims management team is unable to work with the employer to facilitate a worker’s return to modified duty. With specific restrictions, such as the maximum weight the injured worker can lift or the period of time the worker can sit or stand, it is more likely that the employer can create modified tasks for the injured worker. It is important the PCP re-evaluate restrictions during each office visit so the modified-duty assignment can progress toward full duty, or at least toward the worker’s maximum capability. If the injured worker is unable to increase activities over time, the physician should re-evaluate the current treatment regimen and consider whether the injured worker has reached MMI.

If a specialist is providing the majority of an injured worker’s care, the PCP should assign restrictions in conjunction with the specialist. Because it is important to update the restrictions often, the PCP should communicate regularly with the specialist to discuss changes in restrictions, or the PCP can re-examine the worker for this purpose. In either case, the restrictions given must be the same.

Note: In cases where a specialist is primarily treating an injured worker, the PCP is still responsible for care coordination and for determining restrictions. The PCP should schedule office visits as appropriate in order to meet these obligations.

Educating Injured Workers

To encourage injured workers to be active participants in their recovery rather than passive recipients of medical care, the PCP should thoroughly discuss the diagnosis, treatment plan and return-to-work plan with the injured worker.

It is important for the PCP to outline what the injured worker can expect and to define the worker’s responsibilities with regard to the recovery process and activities that are appropriate outside of work.

Communication with All Parties

Most communication between the medical provider and Pinnacol is specific to a claim, and each claim is assigned a claim number. Claim-specific correspondence to Pinnacol must include the claim number. Pinnacol's medical case manager and claims representative assignments can be found by logging in to Pinnacol Online through the Pinnacol.com website.

Pinnacol's claims management team must have an ongoing treatment plan for all open claims, including clearly defined physical restrictions and an anticipated date of MMI. It is especially important to send legible office notes immediately when there is a change in the injured worker's condition or a change in the treatment plan. The PCP is expected to communicate routinely with all parties to the claim as outlined in the Participation Standards located in Appendix A of this manual.

Scheduling and Wait Time

The majority of workers receiving treatment continue to work while recovering from an on-the-job injury. Therefore, any time away from work to attend medical appointments impacts productivity. It is important that medical appointments are scheduled promptly and that wait time is minimized.

Primary Care Clinics

- Clinics must have provisions for walk-in/urgent care injured workers during standard business hours.
- Office wait time for walk-in/urgent care injured workers should not exceed one hour. If necessary, on-call PCPs may be used to render urgent care treatment in accordance with the Primary Care On-Call PCP Policy referenced later in this section.
- Office wait time for scheduled appointments should not exceed 30 minutes.
- Clinics must provide treatment in non-urgent cases within 48 hours.
- Injured workers who make rescheduling requests should be seen within three business days of the original appointment.
- In cases where the injured worker does not attend a scheduled appointment, the PCP will:
    - Notify Pinnacol claim staff of the no-show via fax or email within 24 hours.
    - Reschedule the appointment within three business days from the date of the missed appointment and notify the claims representative when the appointment has been rescheduled.
    - Notify the claims representative to schedule a demand appointment, if the injured worker cannot be contacted.
        - **Note:** Neither the injured worker or clinic should reschedule a demand appointment. Please contact the claims representative if scheduling conflicts arise.

Specialist Clinics

- Injured workers should have an appointment scheduled within one business day from receipt of the referral and should be seen within five business days.
- Injured workers who make rescheduling requests should be seen within three business days of the original appointment.
- The clinic shall reschedule the appointment within three business days from the date of the missed appointment and notify the claims representative when the appointment has been rescheduled.
- Once a decision for surgery has been made, the specialist shall make best efforts to perform nonemergency surgery within 10 business days. If authorization is required, the specialist shall make best efforts to perform nonemergency surgery within 10 business days after receipt of authorization. Please reference Section 4 – Utilization Management of this manual for information about when surgical authorizations are required.

On-Call Provider Policy

On-call providers are physicians or mid-level practitioners who have limited rights and responsibilities under the Network Group Agreement and are not credentialed group participants. The purpose of on-call providers is to provide temporary coverage for group participants who are ill or out of town.

An on-call provider must transition all follow-up care to a group participant.

Referral Management Program

As case manager, the ***SelectNet*** PCP is responsible for the overall coordination and oversight of the injured worker's medical care. This includes initiating all referrals. The following sections outline ***SelectNet*** PCPs' responsibilities pertaining to these topics.

A complete list of ***SelectNet*** participants can be found by selecting "Manage ***SelectNet*** Providers" on Pinnacol.com in the quick links section.

Referral Procedure for *SelectNet* PCPs

Pinnacol's network referral program emphasizes the primary care (gatekeeper) model:

- The PCP should make referral to the ***SelectNet*** specialist and schedule the initial specialist visit within two business days from the date the need for specialist treatment was identified.
- The ***SelectNet*** specialist must see the injured worker within five business days. If the injured worker cannot be seen within five business days of the referral, another ***SelectNet*** specialist should be used.
- The PCP office should provide the injured worker a copy of the referral and any pertinent medical information necessary to ensure the initial specialist appointment is of value.

Referrals for Ancillary Services

In addition to primary care and specialist medical providers, ***SelectNet*** also offers ancillary care services. Please refer to the ***SelectNet*** directory for a listing of providers offering ancillary services in their respective geographical service areas.

If a situation occurs with any rehabilitation or durable medical equipment referral or prescription referral policy that could delay or prolong treatment, the claims management team should be contacted for assistance.

Prescription and Over-the-Counter Medication Dispensing Policy

In some cases, clinics offer medication-dispensing services to injured workers through an in-house pharmacy. In these instances, the provider should dispense only a one-time 14-day supply of medication(s) at the initial visit. Following this initial fill, and if the injured worker requires additional medications, future medications must be filled through Pinnacol's pharmacy benefits management (PBM) program. Pinnacol requires strict adherence to this policy.

In part, this policy helps to address ongoing concerns over opioid abuse by patients, whether inadvertently or purposefully. When an injured worker fills a prescription through Pinnacol's PBM, monitoring for contraindicative medications and medication abuse occurs, resulting in reduced risk of adverse reaction or abuse.

Additionally, and as detailed in the Colorado Department of Regulatory Agencies' Division of Professions and Occupations Policy for Prescribing and Dispensing Opioids, providers who prescribe and dispense opioids should:

- Follow the same guidelines;
- Use the Colorado Prescription Drug Monitoring Program;
- Be informed about evidence-based practices for opioid use in health care and risk mitigation;
- Educate patients on appropriate use, storage and disposal of opioids; risks; and the potential for diversion; and
- Collaborate within the integrated health care team to decrease over-prescribing, misuse and abuse of opioids.

Importantly and according to the same policy referenced above, "opioid prescribers and dispensers must conform to the regulations set forth by the respective licensing board and other laws." https://www.colorado.gov/pacific/dora/Pharmacy

Out-of-Network Referrals

All ***SelectNet*** providers should contact the claims management team to discuss referral care when it is not available within the ***SelectNet*** network or if the provider's independent medical judgment necessitates using an out-of-network provider.

Use of Mid-Level Practitioners

The ***SelectNet*** PCP is responsible for ensuring that injured workers receive appropriate, timely and cost-effective care. To do this, the PCP may utilize mid-level practitioners. Colorado workers' compensation law clearly limits the scope of practice of physician assistants (PAs) and nurse practitioners (NPs). Therefore, the PCP must maintain ongoing care coordination, including:

- Reviewing and co-signing medical records;
- Reviewing any change in work status or return to full duty;
- Completing and signing return-to-work task letters;
- Determining when an injured worker reaches MMI; and
- Determining whether permanent impairment exists at MMI.

Other limitations of PAs and NPs include the following:

- A supervising physician must review and sign (electronic signature accepted) the chart of every injured worker seen by a PA no later than seven days after the injured worker was seen;
- A physician may not supervise more than four PAs at a time;
- PAs may not perform any services that the supervising physician is not qualified or authorized to perform; and
- NPs with prescriptive authority must maintain a formal collaborative agreement with a Colorado licensed physician outlining their respective duties.
- The authorized treating physician must evaluate the injured worker within the first three visits to the office. 7 CCR 1101-3, Rule 16-5(A)(6)(a) and (c)

Only PAs or NPs who are supervised by a ***SelectNet*** network participant operating under the same Network Agreement can become network participants. The supervising PCP must maintain network affiliation in order for the PA or NP to remain network participants.

Maximum Medical Improvement (MMI)

According to the Workers' Compensation Act of Colorado (the Act), MMI is defined as "a point in time when any medically determinable physical or mental impairment as a result of injury has become stable and when no further treatment is reasonably expected to improve the condition." [C.R.S. 8-40-201(11.5)]. It is not permissible to declare MMI and assign a future date to that decision.

The definition of MMI stated above indicates that an injured worker's need for maintenance care must not delay a finding of MMI. The statute goes on to state, "The requirement for future medical maintenance which does not significantly improve the condition … shall not affect a finding of maximum medical improvement." [C.R.S. 8-40-201(11.5)].

It is important that the ***SelectNet*** PCP not delay a determination of MMI when an injured worker has no job to which he or she may return. The ***SelectNet*** PCP is the appropriate physician to render an opinion on MMI.

Once it is determined that an injured worker has reached MMI, the claims management team must address whether or not, and to what extent, the carrier is liable for permanent disability benefits. It is imperative that permanent disability be evaluated by the PCP or specialist at the same time MMI is reached. For more information on permanent disability, see Permanent Impairment later in this section.

Closure Based on Noncompliance or Nonmedical Reasons

An authorized treating provider may close a case when the patient is noncompliant with treatment or for other nonmedical reasons.

If the PCP refuses to provide medical treatment to an injured worker or discharges the injured worker from medical care for nonmedical reasons when the injured worker requires medical treatment to cure and relieve the effects of the work injury, the physician must provide written notice of the refusal or discharge. Within three business days from the refusal or discharge, the notice must be sent by certified mail, return receipt requested, to the injured worker and insurer. The notice must explain the reasons for the refusal or discharge and must offer to transfer the injured worker's medical records to any new authorized physician on receipt of a signed authorization from the injured worker. For template letter, flowchart and reimbursement information, refer to Desk Aid #15 on the DOWC website.

Disputes Regarding MMI

If an injured worker disputes a finding of MMI, he or she can request a Division Independent Medical Evaluation (DIME) from the DOWC. The finding of the DIME physician regarding MMI is binding, except when overcome by clear and convincing evidence.

At times, the claims management team may request a DIME. This typically occurs when more than 24 months have elapsed since the date of injury, and when a non-DIME physician has examined the injured worker and has placed him or her at MMI.

Permanent Impairment

Once MMI is declared, the workers' compensation carrier is required to determine whether the injured worker is legally entitled to some form of permanent disability benefits.

The Act requires that all ratings for impairment are based on the facts of the case in accordance with the appropriate American Medical Association (AMA) Guides. The DOWC may not impose requirements contrary to those of the AMA Guides.

In order for a carrier to address whether permanent disability benefits are to be paid, the occupational injury or disease must be rated to determine if any permanent impairment exists. Impairment means "the loss of, the loss of use of or the derangement of any body

part, system or function." Examples would be loss of motion of an extremity, amputation, loss of hearing, etc.

Usually the ***SelectNet*** PCP will be the PCP evaluating whether or not permanent impairment has been sustained as a result of the occupational accident or exposure. A PCP who is not Level II-accredited through the DOWC can form an opinion on permanent impairment, but only a Level II-accredited physician can assign a physical impairment rating.

MMI and permanent impairment should be determined at the same visit. If this requirement cannot be met, the claims management team should be notified immediately.

When the PCP is completing the rating, the ***SelectNet*** standard for the acceptable period between statement of MMI and receipt of the rating by the claims management team is 14 calendar days.

This deadline is critical because delay in claim closure may result in inaccurately calculated and delayed benefits to an injured worker, resulting in further administrative issues.

When the PCP refers the injured worker to another ***SelectNet*** provider for completion of the rating, the ***SelectNet*** standard for the acceptable period between statement of MMI and receipt of the rating by the claims management team is 30 calendar days from the date of the referral.

Once a permanent impairment evaluation is complete, the Level II-accredited physician must complete a narrative report clearly documenting how the rating was derived using the appropriate AMA Guides. The appropriate worksheets should be included, and apportionment of previous injuries should be provided, if applicable.

Level II-accredited physicians are required to rate permanent impairment in accordance with current DOWC Rules.

Disputes Regarding Permanent Impairment Ratings

If an injured worker disputes a permanent impairment rating, he or she can request a DIME from the DOWC. The findings of the DIME physician regarding the permanent impairment rating are binding, except when overcome by clear and convincing evidence.

Discharging the Injured Worker from Care

After MMI has been reached, the PCP may need to provide maintenance care, perform post-MMI evaluations, rescind MMI or provide an opinion as to whether an injured worker's claim should be reopened. The following sections explain the responsibilities of ***SelectNet*** PCPs with regard to these topics.

Maintenance Care after MMI

If additional treatment or medication is medically necessary for an injured worker to remain at MMI or to prevent deterioration of a condition, the PCP must specify the maintenance care required when permanent impairment is determined. The treatment or medication

must be reasonable, necessary and related to the injury. On the WC164, the PCP must state the type, frequency and duration of medication or treatment needed.

Post-MMI Evaluation

If an injured worker requests additional treatment after MMI has been reached, or after a 60-day lapse in treatment on a non-lost-time claim, the PCP must first call the claims team to obtain authorization for a one-time evaluation.

After the evaluation, the PCP should complete the Physician Assessment of Additional Need for Treatment after MMI form, located in Appendix B of this manual, and return it to the Pinnacol claims management team identified on the MMI form. Following its review, the claims management team will notify the PCP regarding further authorization for treatment.

Rescinding MMI

With few exceptions, only the physician who placed the worker at MMI can rescind MMI. In order to rescind MMI, the treating physician should follow the procedures outlined in the applicable section above. After communicating with the claims management team and obtaining authorization to continue treatment, the PCP should provide a current treatment plan, as in any ongoing claim.

Reopening a Claim

Visit the Injury Reporting and Compensability Time Frames portion of this manual, located in the Regulatory Requirements - Section 2, for important information related to this topic.

Utilization Management

Section 4

Medical Management

In addition to complying with the responsibilities outlined in the foregoing sections, ***SelectNet*** PCPs should schedule ongoing visits and carefully monitor the patient's progress until Maximum Medical Improvement is reached. Additionally, PCPs are expected to cooperate with Pinnacol's utilization management program. This includes, but is not limited to, providing appropriate documentation stating medical necessity, interacting with Pinnacol's claims management teams when questions arise and following Pinnacol's appeals process when disputes occur.

Pinnacol Assurance Utilization Management Program

Pinnacol's utilization management program has been developed to optimize clinical outcomes and to ensure appropriate utilization of medical resources.

This program uses portions of the Workers' Compensation Act of Colorado (the Act) [C.R.S. 8-14.5-101, et seq.] and Rules of Procedure (Rules 16, 17, 18) adopted by the Division of Workers' Compensation (DOWC). The Act and the Rules can be found at www.colorado.gov/pacific/cdle/dwc.

The components of this program are the prior authorization request process and Pinnacol's physician advisor program.

Prior Authorization

Except in emergent situations, clinics should verify the claim is open, active and eligible for medical benefits before rendering treatment or making referrals for other services.

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

According to Rule 16, prior authorization for payment is required:

- When a prescribed service exceeds the recommended limitations set forth in the Medical Treatment Guidelines;
- When prior authorization is required for a specific service in the Medical Treatment Guidelines;
- When a prescribed service is identified in the Medical Fee Schedule as requiring prior authorization for payment; and
- When a prescribed service is not identified in the Medical Fee Schedule.

Requests for prior authorization should include:

- A statement regarding the diagnosed condition;
- The medical documentation supporting medical necessity;
- The proposed treatment plan, including expected duration of services being requested; and
- Anticipated benefit(s) of the recommended procedure.

If insufficient information is submitted, the medical case manager will attempt to obtain the needed information from the provider. If the medical case manager is unable to obtain this information after reasonable efforts, a denial is sent to all parties. To expedite decision-making, all requests for prior authorization of medical services should be directed to Pinnacol's medical case managers.

Acceptance of prior authorization requests will be provided by phone or in writing by the medical case manager within seven business days from receipt of the provider's complete request.

Denial of prior authorization requests will be provided in writing to all parties within seven business days from receipt of the provider's complete request.

Physician Advisor Program

Pinnacol's physician advisor program, established in 1997, is staffed by Colorado physicians of diverse specialties. The program complies with Rule 16, which requires that physician advisors (PA) are physicians or other health professionals who are in the same or similar specialty as would typically manage the medical condition, procedure or treatment under review.

The role of the PA is to provide guidance and advice, consistent with the Medical Treatment Guidelines and current evidence-based medicine, to Pinnacol's claims and case management staff. The PA conducts an independent review related to the specific treatment request and then completes a dictated summary of his or her recommendation.

When the PA asserts that the requested service is necessary and appropriate, the medical case manager will promptly authorize the requested service and will notify the requesting provider by phone within seven business days from receipt of the provider's completed request. The medical case manager will also notify all parties in writing.

When the PA recommends denial of a request, he or she will dictate a medical opinion to support the denial. A written denial, including the PA's medical opinion, name and professional credentials, will be mailed to all parties within seven business days from receipt of the provider's complete request.

Disputes regarding prior authorization decisions will be resolved according to the processes outlined in Rule 16.

Provider Responsibilities and Quality Management

Section 5

Provider Initial Credentialing and Re-Credentialing Processes

Pinnacol is dedicated to maintaining an occupational health network of highly qualified, competent providers. Our credentialing program includes a review of network need, verification of primary sources through an external credential verification organization (CVO) and the use of two separate credentialing committees. We use an industry-standard process to collect and verify a provider's professional qualifications and experience. All committee members who participate in credentialing activities are required to maintain the confidentiality of each provider's information.

Initial Credentialing

Practitioners requesting ***SelectNet*** affiliation are required to meet Pinnacol's minimum credentialing requirements and are required to pay an initial, one-time, nonrefundable credentialing fee regardless of Pinnacol's affiliation decision.

In order to begin the credentialing process, the practitioner must submit a current and complete initial credentialing packet to the Provider Relations Specialist (PRS) assigned to the contract.

Once received, the completed credentialing packet is sent to the CVO for verification. The CVO findings are returned to Pinnacol for review and approval by the Credentialing and Quality of Service Committee (CQSC). The practitioner will be notified of acceptance or denial following CQSC review.

Pinnacol's initial credentialing cycle is two years in most cases.

Re-Credentialing

Following the initial credentialing cycle, practitioners are required to complete re-credentialing every two years to maintain ***SelectNet*** affiliation.

In cases of re-credentialing, the CVO will provide the re-credentialing packet to the practitioner for completion. In order to avoid removal from the network directory and disaffiliation from ***SelectNet,*** the practitioner should complete the packet and return it directly to the CVO within 30 days of receipt.

Once the packet is received and processed, the CVO findings are returned to Pinnacol for review and approval by the CQSC. The practitioner will be notified of continued acceptance or denial following CQSC review.

Pinnacol should be notified in writing when a practitioner no longer needs to be re-credentialed.

Radiology and Rehab Service Providers

Radiology and rehab service providers have been delegated credentialing verification responsibilities and shall verify that each group participant meets Pinnacol's ***SelectNet*** credentialing standards as listed in Exhibit B of the contractual agreement. At its sole discretion, Pinnacol may audit the provider's credentialing activities as they relate to ***SelectNet*** participation in order to ensure compliance with the policy noted above.

Care Management Documentation Requirements for SelectNet Participants

When communicating about an injured worker's care, ***SelectNet*** providers must provide the following components:

- Mechanism of injury;
- Causality assessment (if appropriate);
- Current condition of injured worker;
- Diagnosis;
- A clear description of the treatment plan (e.g., specific treatment information, timeline, functional gain goals);
- Medications;
- Specific work restriction information as assigned by the primary care provider (PCP);
- When return-to-work is anticipated;
- Anticipated Maximum Medical Improvement (MMI) date as assigned by the PCP; and
- Date of next appointment.

Return-to-Work (RTW) and Modified Duty

When addressing modified duty or full duty return-to-work, provider communication, whether provided on a WC164 form or office dictation, should include the following:

- Injured worker's work status, including effective date;
- Specific work restrictions (do not write "same as last visit," "as tolerated," "as needed," "per specialist report" or "continue with same work restrictions"); and
- The date of the injured worker's next scheduled appointment.

Include physician's name, clinic name, date of report, address and phone number on all WC164 forms. If modified duty is not available or if the employer is unsure whether it is possible to create a modified duty position, contact the Pinnacol claims representative assigned to the claim. When addressing a Rule 6 offer of modified employment, the PCP must respond within two business days of receipt. The letter must be signed only by a physician who has treated the injured worker.

Provider Orientation

The purpose of this orientation program is to train providers and their staff regarding Pinnacol policies and procedures and the use of this provider manual, and to provide an overview of the Workers' Compensation Rules of Procedure (WCRP) and DOWC's Medical Treatment Guidelines. This required orientation is normally completed during an in-person visit from the PRS assigned to the clinic.

Provider's Notification of Changes to Pinnacol

SelectNet providers are required to notify Pinnacol's Provider Network Management team of any changes in business address, treatment locations, business telephone numbers, tax ID numbers and staff as soon as these changes occur. It is extremely important that provider information is accurate, as the ***SelectNet*** directory is available through Pinnacol's website and is widely used by Pinnacol staff and the ***SelectNet*** provider community.

Employer/Client Management – Primary Care Providers (PCPs)

Pinnacol recommends that PCPs establish relationships and outline service expectations with their employer designators. Designation reports are available via the Pinnacol website.

SelectNet providers must provide healthcare services to the injured workers employed by Pinnacol policyholders.

Quality Improvement Program

Pinnacol requires that providers develop and maintain a quality improvement program that resolves problems and complaints; includes satisfaction surveys, a physician peer review and chart auditing; and addresses all performance requirements outlined in this manual.

Pinnacol provides performance feedback to help providers assess and enhance their performance. When opportunities for improvement are identified, providers shall develop corrective action initiatives to resolve performance deficiencies. Upon request, the provider shall submit to Pinnacol a copy of the quality improvement plan within the established time frame.

Billing

Providers must bill Pinnacol in accordance with the policies and procedures set forth in DOWC Rules 16 and 18. To help ensure appropriate billing practices, all provider bills are subject to Pinnacol's random bill audit program. Overpayment resulting from improper billing may be subject to Pinnacol's offset and recoupment process.

Bills for approved health care services rendered to injured workers covered by Pinnacol **must be submitted with the assigned claim number** and according to the time frame specified in your ***SelectNet*** Agreement.

All bills for approved health care services rendered to injured workers covered by Pinnacol must be submitted directly to Pinnacol. A provider may not directly bill or receive payment from an injured worker or employer insured by Pinnacol unless the claim has been denied by Pinnacol. ***SelectNet*** providers cannot bill an injured worker for the balance of any charges not fully paid by Pinnacol unless the service is deemed not related, not medically necessary and/or not medically reasonable.

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

According to the DOWC Rule 16, Pinnacol is permitted thirty days to process bills. Providers are requested not to resubmit bills until at least thirty days after the first submission. Submitting bills prior to thirty days results in duplicate bills and rework for the providers and Pinnacol.

DOWC Medical Fee Schedule

Pinnacol reimburses at rates established by the Colorado DOWC fee schedule (Rule 18), less any applicable contractual discount in effect at the time services are rendered. Rule 18-1 identifies the current editions of publications to be referenced for billing codes and can be accessed at the DOWC website.

Electronic Billing

Pinnacol strongly encourages electronic billing and in some cases may require this format.

Pinnacol works with the following electronic transaction clearinghouses:

Change Healthcare (accommodates CMS -1500 and UB-04 bill submissions to Pinnacol):

- Phone number: 866.817.3813
- Pinnacol payer ID number: 84109
- https://www.emdeon.com/papertoedi
- Formerly known as Emdeon

Optum Intelligent EDI (accommodates CMS-1500 bill submissions to Pinnacol):

- Phone number: 800.765.6705
- Pinnacol payer ID number: CCIA1
- https://www.optum.com/providers/revenue-cycle-management/claims-connectivity/billing-claims/intelligent-edi-physician.html?v=optum.com/edi

SSI ClearPlus (accommodates CMS 1500 and UB04 bill submissions to Pinnacol):

- Phone number: 800.820.4774
- Pinnacol payer ID number: 99999-0636
- http://www.thessigroup.com/solutions/Clearinghouse_Services/ClearPlus/
- Also integrates into Epic's Resolute Billing workflow and processes

If you have not already established a relationship with one of these companies, please contact your option of choice and establish an account.

Paper Billing

All health care providers shall use only the following billing forms or electronically produced formats when billing for services:

(1) CMS (Centers for Medicare & Medicaid Services) 1500 – shall be used by all providers billing for professional services, durable medical equipment (DME) and ambulance with the exception of those providers billing for dental services or procedures; health care providers shall provide their name and credentials in an appropriate box of the CMS 1500.

(2) UB-04 – shall be used by all hospitals, hospital-based ambulance/air services, children's hospitals, Critical Access Hospitals, Veterans' Administration facilities, home health and facilities meeting the definitions found in Rule 16-2 when billing for hospital

services or any facility fees billed by any other provider, such as Ambulatory Surgery Centers, except for urgent care, which may use the CMS-1500.

(3) American Dental Association's Dental Claim Form, Version 2012 – shall be used by all providers billing for dental services or procedures.

(4) With the agreement of the payer, the ANSI ASC X12 (American National Standards Institute Accredited Standards Committee) or NCPDP (National Council for Prescription Drug Programs) electronic billing transaction containing the same information as in (1), (2) or (3) in this subsection may be used.

Completing Billing Forms

UB-04 and CMS-1500 forms must be filled out completely in order for Pinnacol to process payment. If Pinnacol receives incomplete information on any bill submission forms, payment will be delayed and the form(s) will be returned to the provider for completion. The following instructions should be followed when completing forms UB-04 and CMS-1500 to ensure prompt consideration for payment.

UB-04 Forms: Hospitals and providers billing for dental services or procedures must complete all fields mandated by Medicare. Field #62 (Insurance Group No.) must contain Pinnacol's seven-digit claim number for the case being billed. Field #82 (Attending Phys. ID) must contain the physician's (or physician assistant's/nurse practitioner's) name and Colorado license number.

CMS-1500 Forms: Please see the Appendix C at the back of this manual for "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 credential of the actual provider of service.

Paper bills may be submitted to:

Medical Payments Team
Pinnacol Assurance
P.O. Box 469013
Denver, CO 80246-9013

Payment for Visits on Denied Claims

Pinnacol is not responsible for any medical or indemnity 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.

Pinnacol will pay for an initial visit to a ***SelectNet*** provider when one of the following circumstances arises:

- Pinnacol arranges for the injured worker to be seen by the ***SelectNet*** provider; or
- Pinnacol's client (the policyholder) has designated the ***SelectNet*** provider, and has sent the injured worker to the provider.

Reconsideration

Explanation of Benefits (EOB) forms received for reconsideration (or a "rebill") are considered on a case-by-case basis. Generally, when Pinnacol receives a rebill, the original entry is reversed, the new entry is entered, and the additional payment due or credit to be recouped is calculated. Bills can be appealed via the online system 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)**.

Pinnacol's Responsibilities

Section 6

Promoting *SelectNet*

Pinnacol promotes the designation of ***SelectNet*** PCPs through contacts between the employer and our underwriting, loss prevention and marketing staff.
In addition, when we receive calls from injured workers and employers asking where to obtain medical treatment, callers are informed of ***SelectNet*** PCP options.

While this program is generally effective, it does not guarantee that any particular percentage of policyholder designations or injured workers will be directed to network providers through Pinnacol's marketing efforts.

Printed Brochures and Newsletters

Pinnacol offers brochures that promote the benefits of using ***SelectNet*** providers. These brochures are distributed to employers by mail and email, at seminars, and through Pinnacol's marketing staff and insurance agents. Pinnacol also publishes newsletters (*Focus* and *Provider Pulse*) that often highlight ***SelectNet*** and provide updates on network changes.

Meetings with Safety Groups and Trade Associations

Pinnacol's safety services and marketing staff meet with safety groups and associations who are required to designate providers as a condition of their policy. Pinnacol encourages groups and associations to designate ***SelectNet*** providers.

Team Management of Claims

In managing claims, medical case managers and claims representatives may use ***SelectNet*** providers for special services such as independent medical exams (IMEs). The claims management teams educate employers on the benefits of using the network and of designating ***SelectNet*** PCPs.

SelectNet Provider Directory

The ***SelectNet*** provider directory is available to the public and can be accessed by visiting Pinnacol.com. Pinnacol's policyholders can designate ***SelectNet*** providers directly from the online directory.

Provider Communication

Primary Contact – The Provider Relations Specialist (PRS)

All ***SelectNet*** providers are assigned a PRS as their primary point of contact with Pinnacol. The PRS staff is here to assist you with questions or issues related to your ***SelectNet*** contract. As a general rule, communication regarding a specific injured worker should be directed to the appropriate claims management team; however, your PRS is available to assist with any challenges that may arise. Pinnacol's PRS staff may be reached at 303.361.4945.

Provider Orientation

The provider orientation provides a broad overview of ***SelectNet*** policies and procedures, online tutorials, workers' compensation resources, and other topics, including:

- The ***SelectNet*** Provider Manual;
- Utilization management and review guidelines;

- Case management; and
- Billing and reimbursement.

SelectNet Provider Seminars and Conferences

Pinnacol generally conducts at least one seminar or conference each year for ***SelectNet*** participants. These seminars are clinically focused and presented by experts in the field. CME credit is often available to attendees.

Health Headliners Program

The Health Headliners program offers the opportunity for ***SelectNet*** providers to educate Pinnacol's staff about specific clinical topics and procedures. To inquire about presenting at a Health Headliner session, please call 303.361.4945 and speak with the PRS assigned to your contract.

Provider Pulse Newsletter

Provider Pulse is an online newsletter that is published quarterly and distributed to ***SelectNet*** providers and their staff. Updates to ***SelectNet*** policies and procedures and Colorado regulatory requirements, as well as discussions of relevant medical topics, are included. If you are interested in submitting an article for publication, please call 303.361.4945 and speak with the PRS assigned to your contract.

Employer Designation Reports for Primary Care Providers (PCPs)

SelectNet PCPs have online access to employer designation reports. These reports provide contact information for the employers who have designated the clinic to treat their injured workers and assist the PCP with client-focused marketing efforts.

Network Management

SelectNet Credentialing and Quality of Service Committee (CQSC)

The CQSC was established to provide oversight for network quality of service and for the credentialing of potential and current ***SelectNet*** providers. The CQSC is a majority-driven interdisciplinary team composed of Pinnacol employees and at least three external medical providers. Pinnacol staff members who serve on the CQSC may include:

- Senior medical director (chair);
- Associate vice president of Provider Network Management;
- Director of Provider Network Management;
- Provider relations manager;
- Business director;
- Medical case management director; and
- Claims staff.

Pinnacol PRSs, a Pinnacol attorney and the Pinnacol credentialing coordinator also attend CQSC meetings.

Network Affiliation Committee (NAC)

NAC is a majority-driven interdisciplinary team, at least 50 percent of which is composed of external medical providers. NAC serves to review and address quality of care concerns. Individuals who may serve on the NAC include:

- Senior medical director (chair).
- Associate vice president of Provider Network Management.
- Director of Provider Network Management.
- Provider relations manager.
- External medical providers (at least three).
- Business director.
- Medical case management director.

NAC and CQSC meetings are closed sessions to protect the privacy of all involved.

Network Affiliation and Disaffiliation

The Provider Network Management team uses a formal process to admit providers and approve contracts into ***SelectNet*** and, when necessary, to disaffiliate them from the network. The decision to affiliate, sanction, take other corrective action or disaffiliate a provider or a contract is made by the CQSC. For specific information related to the policies and processes used to address such issues, please review Appendix D.

Network Performance

The Provider Network Management team monitors ***SelectNet*** clinic and provider performance:

- Performance profiling;
- Provider disputes/grievances/complaints/recognition information; and
- Feedback logs.

Performance Profiling Overview

Pinnacol produces performance reports for ***SelectNet*** primary care clinics. These reports include cost data related to patients assigned to each clinic and compare that information to the cost data for other ***SelectNet*** provider clinics. The information gained through this process is educational for ***SelectNet*** providers, because it allows comparison of practice and performance to that of one's peers.

Eligible ***SelectNet*** providers can access profiling reports by logging in to Pinnacol online. Pinnacol does not share these reports publicly. They are shared only with ***SelectNet*** providers and are for informational purposes only.

Financial remuneration to ***SelectNet*** providers is not based upon any of the measurement criteria contained within these reports.

Provider Disputes, Grievances and Complaints

If a ***SelectNet*** provider has a dispute with Pinnacol or with another ***SelectNet*** member(s), that provider may bring forth such disputes, grievances and complaints to their assigned PRS for research and resolution.

Examples of issues that may be brought to your PRS include, but are not limited to:

- Quality of care;
- Quality of service;
- Pinnacol's assessment of provider performance;
- Network administration;
- Contract provisions; and
- Billing and reimbursement.

Your PRS will document and log the dispute, grievance or complaint in our internal provider feedback log.

Provider Feedback Tracking System

Pinnacol's Provider Network Management team maintains a provider feedback tracking system to document positive and negative comments about ***SelectNet***. If an issue arises with another ***SelectNet*** provider, or with a Pinnacol staff member, please call your PRS. The specifics regarding each entry — including the source and the subject of the comment, issue type and resolution of the issue — are documented. The results are compiled to identify issues and trends.

Providers or clinics receiving five valid provider feedback complaints within a credentialing or contract cycle will be presented to the CQSC for review and possible disciplinary action. In situations deemed egregious in nature, a provider or clinic may be presented to the CQSC with fewer than five valid provider feedback complaints. Please see Appendix A for more information.

Appendices

Appendix A – SelectNet Participation Standards

PCP Participation Standards

Pinnacol considers primary care providers (PCPs) the heart of ***SelectNet***. Pinnacol expects PCPs to:

- Thoroughly evaluate, treat and educate the injured worker; and
- Adhere to guidelines and procedures established by Pinnacol and the DOWC, including those related to case management, communication with Pinnacol, wait times, referrals and utilization management.

Nothing in this manual should be construed as dictating to any provider the type or duration of treatment or the degree of impairment of an injured worker.

Case Management

The PCP is responsible for:

- Determining causality;
- Coordinating referrals for further evaluation and treatment;
- Monitoring functional gains and progress until Maximum Medical Improvement (MMI) is reached;
- Determining physical restrictions, and clearly communicating the restrictions to all parties to the claim; and
- Determining MMI and Permanent Partial Disability (PPD), and discharging the patient from care.

Communication with Pinnacol

The PCP must:

- Return calls to Pinnacol within two business days;
- Respond to written job offer and job description within two business days. If the PCP is deferring to the specialist for the assignment of work restrictions, the PCP remains responsible for this time requirement;
- Provide the initial Form WC164 to Pinnacol so that it is received within three business days from the date of service;
- Provide medical records and legible office visit notes to Pinnacol so that they are received within seven business days from the date of service. Medical records and notes must include the following information:
    - Mechanism of injury;
    - Causality assessment on initial and closing visits;
    - Current condition of injured worker;
    - Diagnosis;
    - Treatment plan;
    - Medications;
    - Specific work restrictions;
    - Anticipated date of MMI; and
    - Date of next appointment.

- Provide the closing Form WC164 to Pinnacol so that it is received within 14 calendar days from the date of service;
- Respond in writing by fax or mail to any other written correspondence from Pinnacol so that it is received within 10 business days from the date of the correspondence; and
- Provide notification to the claims management team of any no-shows for appointments within one business day.

Wait Times and Availability

- Wait time for scheduled appointments should not exceed 30 minutes.
- Wait time for urgent care or walk-in visits should not exceed one hour.
- A patient's initial visit should occur within 48 hours of the request for an appointment.
- Health care services must be available Monday through Friday during normal business hours.
- For rural or frontier providers (reference your Agreement's Exhibit B to determine classification), health care services must be available in a manner that adequately addresses community needs.

PCP Referrals

- The PCP should initiate all referrals and schedule initial appointments for the injured worker.
- Referrals should be to ***SelectNet*** providers, unless the service is not available within ***SelectNet***.
- Pinnacol must be advised before the PCP makes any out-of-network referral.

Urgent Care Participation Standards

SelectNet urgent care providers should offer only emergent care services and should direct injured workers to their employer for a list of designated providers for follow-up care.

All urgent care facilities must be certified by the Urgent Care Association of America (UCAOA) to be recognized for a separate facility payment for the initial visit per the Division of Workers' Compensation, 7 CCR 1101-3, Rule 18, Urgent Care Facilities.)

Communication with Pinnacol

The urgent care provider must:

- Return calls to Pinnacol within two business days;
- Fax or mail the initial evaluation report to Pinnacol so that it is received within seven business days from the date of service; and
- Respond in writing by fax or mail to any other written correspondence from Pinnacol within 10 business days from the date of the correspondence.

Wait Times

- Wait time for urgent care or walk-in visits should not exceed one hour.
- Wait time for scheduled appointments should not exceed 30 minutes.

Urgent Care Provider Referrals

- The urgent care provider must refer all follow-up care to the employer's chosen workers' compensation designated provider. **Note:** Follow-up for suture removal is permitted if no other follow-up is needed.
- Referrals should be to ***SelectNet*** providers, unless the service is not available within ***SelectNet***.
- Pinnacol should be advised whenever the urgent care provider needs to make an out-of-network referral.

Specialist Participation Standards

SelectNet specialists are to coordinate care with the PCP to ensure injured workers receive medically necessary and timely care. ***SelectNet*** specialists are expected to follow DOWC treatment guidelines and the procedures and policies established by Pinnacol. These standards address process management issues, including scheduling, communication with PCPs, utilization management and Pinnacol's network referral program.

Referral and On-Call Specialists

Group participants have responsibilities under the terms of the ***SelectNet*** agreement to provide health care services regardless of whether the referral originated with a network or non-network provider. On-call providers, as defined in the ***SelectNet*** agreement, may provide on-call and backup coverage for group participants when a group participant is ill or out of town. Refer to the ***SelectNet*** agreement for information regarding the use of on-call providers.

Should an injured worker require hospital admission and/or surgery, the on-call provider may admit and/or perform the necessary surgery, subject to the limitations and conditions of the Agreement. The on-call provider retains case responsibility for the care of that injured worker until referral back to the PCP for ongoing care management.

If the on-call provider attends to an injured worker (either in a hospital emergency room or in the office of a group participant) and the visit does not require hospital admission or surgery, the on-call provider will transfer case responsibility to the in-network group participant or the PCP, whichever is appropriate, for follow-up care.

Scheduling

The specialist must:

- Schedule appointments within 24 hours of referral;
- Evaluate/treat the injured worker within five business days from date of referral; and
- Perform elective surgery within 10 business days of receiving authorization for surgery from Pinnacol.

Wait Times

- Wait time for scheduled appointments should not exceed 30 minutes.

Specialist Referrals

- Although the PCP should initiate all referrals, in some cases a specialist provider may assume responsibility for a patient's care. In such circumstances, it is the responsibility of the specialist to schedule any referral appointments for the injured worker. In addition, the specialist is also required to meet all other PCP performance-standard expectations outlined earlier in Appendix A.
- Referrals should be to ***SelectNet*** providers, unless the service is not available within ***SelectNet***.
- Pinnacol must be advised before the specialist makes an out-of-network referral.
- When a specialist serves in the role of an urgent care provider, the specialist is expected to primarily provide emergent care. Any follow-up, if necessary, must be referred to the employer's designated provider choice for workers' compensation care.

Procedures

The specialist practice will schedule and perform only those procedures specifically requested in the referral. Procedures requiring prior authorization under DOWC Rule 16 utilization standards must be preauthorized by Pinnacol before they are scheduled and performed. The specialist practice will perform elective surgery within 10 business days of receiving authorization for surgery from Pinnacol.

When scheduling an assistant surgeon, best efforts will be made to use a network provider. Physician assistants and surgical assistants used in the surgical setting are not required to be network providers.

Communication with PCP and Pinnacol after Initial Examination

The specialist must communicate directly with the PCP and the Pinnacol claims management team within 24 hours of the initial exam, and he or she must follow up with a written narrative report within seven business days from each date of service.

Information on the initial narrative report must include:

- Patient's work-related history;
- Mechanism of injury;
- Current condition of injured worker;
- Diagnosis;
- Treatment plan;
- Medications;
- Date of next appointment (if appropriate); and
- Causality assessment (required only when the specialist has assumed the PCP role).

For Ongoing Care

The specialist practice will re-evaluate the treatment plan after each major procedure or series of injections. After each re-evaluation, the specialist will provide updated treatment information to both the referring PCP and Pinnacol. All updated information must be submitted within seven business days from the date of the re-evaluation.

Information on any follow-up narrative reports must include:

- Current condition of injured worker;
- Diagnosis;
- Treatment plan;
- Medications; and
- Date of next appointment (if appropriate).

Postoperative Care and Case Closure

The PCP and the specialist will collaborate to set work restrictions and status during the postoperative period. After the specialist releases the injured worker from postoperative care, the PCP is solely responsible for determining physical restrictions and return to work. Unless otherwise arranged, the PCP is responsible for placing the injured worker at MMI.

Additional Communication Standards

The specialist practice must:

- Notify the claims management team within one business day if an injured worker misses an appointment.
- Return calls to Pinnacol within two business days.
- Respond to letters from Pinnacol within 10 business days from the date of the correspondence.

Rehab Service Provider Participation Standards

Rehab service providers include physical therapists, occupational therapists, speech therapists, massage therapists and acupuncturists.

Rehab service providers will adhere to the following network participation standards, requirements and conditions in addition to all applicable specialist participation standards listed above.

The rehab service provider:

- Will not treat injured workers covered by Pinnacol without a current prescription from the referring physician.
- Will begin prescribed services within two working days of the referral.
- Agrees to provide the written initial report and the discharge report to the referring provider within five days of service.
- Agrees to obtain prior approval from Pinnacol before providing any job site analysis services.

- Agrees to obtain prior approval from Pinnacol before providing any special testing. Examples include but are not limited to functional capacity evaluations (FCEs) and work-hardening and work-conditioning tests. Rehab service provider agrees to provide the complete report from any special tests to the referring provider and Pinnacol within seven days from date of service.
- Agrees to obtain prior approval from Pinnacol if a prescribed service exceeds recommended limitations as set forth in the DOWC's medical treatment guidelines.
- Agrees to document and communicate any requests for additional services to the referring provider responsible for managing the injured worker's care.
- Agrees to send therapy notes to the referring physician.

Psychological Services Provider Participation Standards

The psychological services provider acknowledges and agrees to the following requirements and conditions in addition to all applicable specialist participation standards listed above.

Communication with Pinnacol

Psychological services provider must communicate directly with the PCP and the Pinnacol claims management team within 24 hours of initial exam, and follow up with a written narrative report within seven business days from each date of service.

Information on the initial narrative report must include:

- Patient's work-related history;
- Mechanism of injury;
- Causality assessment;
- Current condition of injured worker;
- Diagnosis;
- Treatment plan;
- Medications; and
- Date of next appointment (if applicable).

For ongoing care, the psychological services provider must provide treatment information to both the referring PCP and Pinnacol whenever the treatment plan is altered. All updated information must be submitted within seven business days from the date of the re-evaluation.

Information on any follow-up narrative report must include:

- Current condition of injured worker;
- Diagnosis;
- Treatment plan;
- Medications; and

- Date of next appointment (if applicable).

Because the PCP is responsible for managing an injured worker's care, the psychological services provider may not make referrals to another health professional, establish physical restrictions or place an injured worker at MMI. The PCP must be consulted and concur with any treatment plans initiated by the psychological services provider.

The psychological services provider must obtain prior authorization from Pinnacol before performing services not specifically addressed in the DOWC Treatment Guidelines, or are in excess of limits as outlined in the Treatment Guidelines, or require prior authorization, as stated in the Treatment Guidelines (see Rule 17).

Delegation of Services

When delegating a portion of a psychological evaluation, test and/or treatment of an injured worker covered by Pinnacol, the psychological services provider must utilize the services of a nonphysician provider who is recognized under Rule 16 and is registered or licensed by Colorado's Department of Regulatory Agencies or is certified by a national entity recognized by the state of Colorado.

All nonphysician providers must be working within the contracting facility and under the direct supervision and responsibility of a credentialed group participant who is also working at the same location.

Appendix B – Provider Assessment of Additional Need for Treatment after MMI

If an injured worker for whom you provided treatment returns for additional non-maintenance care after MMI or after a lapse in treatment of more than 60 days on a non-lost-time claim, please address the following questions and requests in your medical narrative:

- What was the date of the injured worker's last visit?
- What was the date of MMI from the original injury?
- What are the worker's current symptoms/complaints?
- Has there been a new occupational injury or exposure? If yes, please explain.
- Is it medically probable that the injured worker's current symptoms or complaints were caused by a new occupational injury or exposure?
- Is it medically probable that the injured worker's current symptoms or complaints are related to the original compensable injury?
- Has there been a change in condition that necessitates rescinding MMI from the original injury and providing further treatment?
- If additional treatment is needed, please attach your detailed treatment plan, including the type of treatment needed, duration of that treatment and any work restrictions.
- Please state the anticipated date of MMI based on this new treatment plan.

Appendix C – Pinnacol Claims Submission Instructions – CMS 1500

CMS 1500 Box Number	CMS 1500 Form Field Name	Required Information
Box 1a	Insured's ID number	Patient's Social Security number
Box 2	Patient's name	Patient's last name, first name, middle initial
Box 3	Patient's birth date	Patient's birth date in mm/dd/yy format
Box 5	Patient's address	Patient's address with ZIP code
Box 11	Insured's policy group or FECA number	Pinnacol seven-digit claim number
Box 14	Date of current illness	Date of illness, accident date
Box 17	Name of referring provider	Referring provider's name
Box 17b	NPI number	Referring provider's NPI number
Box 21	Diagnosis or nature of illness or injury	Diagnosis code in ICD-10 field* (see restrictions below)
Box 24	Dates of service; place of service; procedures, services or supplies; modifiers; diagnosis pointer; charges; units; rendering provider NPI number	Dates of service; place of service; procedures, services or supplies; modifiers; diagnosis pointer; charges; units; rendering provider's NPI number
Box 25	Federal tax ID number	SSN, EIN or FEIN of provider organization to be paid
Box 26	Patient account number	
Box 28	Total charges	Sum of itemized line charges from Field 24
Box 31	Signature of a provider or supplier and credential (MD, RN, PT, etc.)	Signature or printed name and professional credential of the ***actual*** provider of service
Box 32	Facility name, address, NPI number	Facility's name, NPI number and address where services were provided
Box 33	Provider's/supplier's billing name, address, NPI number	Name and address where payments are to be sent (address must correspond to tax ID number in Field 25)

***Restriction on Use of ICD-10 Codes:** Only complete codes are acceptable.

Appendix D – Process Used to Address SelectNet Provider Quality-of-Service and Quality-of-Care Concerns

Summary	Application of this policy may result in imposition of corrective action, disciplinary action or adverse action, including disaffiliation from the network (through termination of the provider agreement). This guideline does not apply when quality of care or quality of service issues are not involved and disaffiliation (or agreement termination) occurs as a result of • the lack of need for providers in a discipline; • the nonrenewal of a contract for neither a quality of care nor quality of service issue; • a provider ending association with the contracted group; • a provider ceasing its operation; • contract disputes; or • termination of the provider agreement pursuant to disaffiliation-without-cause provisions. These guidelines apply only to network providers that do not meet network standards or requirements for quality of care or quality of service. The Provider Network Management team is responsible for investigating issues that may warrant action, including disaffiliation. Such issues will generally fall into one of two categories: (1) quality of care or (2) quality of service. The Provider Network Management department delegates day-to-day handling of quality of care and quality of service issues to the CQSC. The CQSC delegates quality of care issues and investigations to the NAC. Issues that may warrant investigation and possible action, including disaffiliation, are listed in Sections I and II, which follow. With respect to quality of care concerns, the NAC will report its investigative findings and recommendations to the CQSC, which will adopt the recommendations of the NAC. A provider is entitled to written notice of adverse actions as a result of quality of care issues and may request a hearing regarding such actions. The hearing will be held by an impartial hearing officer; the recommendation of the hearing officer and of the CQSC will be forwarded to the vice president's committee for final action. Regarding quality of service concerns, the CQSC may initiate corrective or disciplinary action, including disaffiliation. A provider is entitled to written notice after a corrective or other disciplinary action, including disaffiliation, is imposed and may request an informal meeting with the CQSC or a subcommittee thereof. The CQSC has the final authority to take action regarding the quality of service concerns it investigates.

Procedure	**I. Quality of Care Concerns** **Issues That Qualify as Quality of Care Concerns** The following are issues that qualify as concerns (the list is descriptive, not exhaustive): • Medical treatment that is not consistent with standards of care within the community; • Unprofessional conduct as defined by the Colorado Medical Practice Act; • Disciplinary actions, sanctions and/or stipulations entered by any medical board or governmental agency; • Unfavorable malpractice claims (judgments or settlements); • Failure to comply with Pinnacol's utilization management program; • Failure to comply with Pinnacol's Quality Initiative standards; and • Failure to deliver or order services at an appropriate point or level of care, including out-of-network referrals. Any ***SelectNet*** provider with five or more valid provider feedback log entries during the last credentialing cycle representing substantiated quality of care issues that are varying or similar concerns must be reviewed by the NAC. A valid Provider Feedback Log entry occurs when a quality of care standard has not been met and is reported to and documented by Pinnacol's Provider Network Management team. Quality of care requirements are outlined in the provider's network agreement, the ***SelectNet*** Provider Manual, the ***SelectNet*** participation standards and the ***SelectNet*** credentialing standards. In addition, the NAC may, in extraordinary circumstances based on the severity of any Provider Feedback Log entries that total any number fewer than five during the last credentialing cycle, consider a provider for review and further action, if warranted. In all cases, when a substantiated Provider Feedback Log issue is determined to have occurred, the ***SelectNet*** provider will receive written notification from Pinnacol noting (1) the issue in question and the performance standard that was not met, (2) information related to how the particular issue was resolved, (3) the number of substantiated issues the provider has accumulated since his or her last credentialing cycle and (4) the total number of issues permitted before a mandatory committee review ensues. **Investigation** 1. An investigation will be conducted when the Provider Network Management team and the medical director determine that a provider is potentially not meeting network quality of care standards. The Provider Network Management team will forward the issue to the CQSC for follow-up. The CQSC will assign the issue and any necessary

investigation to the NAC.

2. The NAC may, at its reasonable discretion:
   - Meet informally with the provider;
   - Collect relevant documentation;
   - Discuss issues with other persons having knowledge of the facts or conduct in question (providers authorize the release of such information by virtue of their network provider agreement);
   - Obtain independent review (e.g., from a physician advisor or other peer provider);
   - Analyze information to determine if further action is warranted; and Take any other steps consistent with the need to reasonably investigate the issue.

Determination

1. If the initial screening reveals that further investigation is warranted, written notice will be sent to the provider. The provider will be permitted 30 days to provide a written response to the issues under investigation.
2. After the 30-day response period has expired, the NAC will report its findings and recommendations to the CQSC.
3. The decision on whether to recommend a particular action, including disaffiliation, will be made by majority vote of the NAC.
4. The NAC will make best efforts to be consistent in its recommendations for like violations; however, the NAC may recommend a more severe action based on a provider's history of prior violations of quality of care standards.
5. The CQSC will adopt the recommendations of the NAC regarding quality of care concerns.
6. The available adverse actions for quality of care concerns include:
   - Denial of participation or denial of renewal application;
   - Suspension of treatment rights for a period of < 14 days;
   - Suspension of treatment rights for a period of >14 days;
   - Emergency suspension of treatment rights;
   - Contract termination/disaffiliation solely of the subject provider;
   - Contract termination/disaffiliation of the subject provider and any affiliated group;
   - Conditional continued affiliation; and
   - Corrective action plans.
7. Action that does not constitute an adverse action includes a confidential letter of concern.
8. If the investigation reveals that no further action is warranted, the NAC

will close the matter and report this result to the CQSC.

9. If the NAC recommends an adverse action, the director of Provider Network Management or his or her designee will send notice to the provider by hand delivery, overnight mail with signature required or certified mail. The notice will include:

   - A description of the recommended action; and
   - The reason(s) for the recommendation.
   - If the recommended action would deny, restrict, suspend or terminate the provider's practice rights in the network for more than 14 days, a statement that the provider may submit a written request, within 30 days after the date of the letter, for a hearing; a statement that the right to a hearing may be forfeited if the provider fails, without good cause, to appear; and a statement that the provider has the following rights at the hearing:
     - To have an attorney or other person of the provider's choice present;
     - To call, question and cross-examine witnesses and to present evidence determined to be relevant by the hearing officer regardless of its admissibility in a court of law; and
     - To provide a written statement of his or her position at any hearing. (**Note:** No hearing is allowed if the reason for the proposed action is suspension or revocation of the provider's license or inability to obtain malpractice insurance.)

Emergency Suspension

An emergency suspension may be imposed only if a provider's care is likely to place injured workers in imminent danger from a quality of care perspective.

1. If the NAC or the medical director and the director of Provider Network Management determines in good faith from the information available that there is an imminent danger or jeopardy to workers, the full NAC or the medical director and the director of Provider Network Management may impose an emergency suspension prior to the standard investigation process.

2. The medical director will notify the provider by telephone of the determination. The medical director will follow up in writing by certified mail, notifying the provider of the emergency suspension of participation in ***SelectNet***. The letter will also inform the provider that an investigation will be conducted and a recommendation will be made within 14 days about whether to continue the suspension. The director of Provider Network Management will ensure that the IT and UR systems are edited to block assignment to the subject provider and block UR approvals.

3. The NAC will investigate and report its findings and recommendations to the CQSC within 10 days.

4. The CQSC will adopt the NAC's recommendations about whether to continue the suspension no later than 14 days after the imposition of the emergency suspension. If the NAC recommends that the quality of care concern can be handled via the standard process, the CQSC will lift the suspension, and the director of Provider Network Management will inform the provider in writing of its decision and of its intent to continue the investigative and decision-making process in the normal course. If the NAC recommends that the suspension is warranted while further investigation is performed, the CQSC will continue the suspension, and the director of Provider Network Management will inform the provider in writing of its decision and of the provider's right to a hearing, as provided in the section above.

Prehearing Procedures

1. If the provider submits, within 30 days after the date of the notice letter, a written request to the CQSC for a hearing, the director of Provider Network Management will provide to the CQSC and the provider a list of three hearing officer candidates. A hearing officer candidate may be an arbitrator recognized by the American Health Lawyers Association or the American Arbitration Association, or he or she may be any other impartial attorney, provided that all candidates have experience in managed care and health care in general. The hearing officer candidate may not be any person who was previously involved in the investigation or decision-making in the case, and may not be an employee or contractor of Pinnacol. Each party will have five business days to rank the candidates in order of choice (1 being the highest ranking). Any candidate receiving a ranking of 3 from either party will be eliminated; the best-ranking candidate of the remaining candidates will be appointed as the hearing officer. Pinnacol and the provider will equally share the costs of the hearing officer, including time spent to prepare for the hearing, attend the hearing, and prepare findings and recommendations thereafter.

2. The parties and the hearing officer will schedule the hearing for a date not fewer than 30 days or more than 60 days after the CQSC's receipt of the request for a hearing, unless the parties mutually agree to a date outside this time frame. The director of Provider Network Management will send written confirmation of the date, time and place of the hearing to the provider and the hearing officer. The notice will also list any witnesses the CQSC intends to call.

3. The parties will have the right to inspect and copy, at the requesting party's expense, any documents relevant to the action in the possession of the other party. The right to inspect and copy does not extend to confidential information referring solely to other identifiable providers.

4. No later than 10 days before the scheduled hearing, the provider will furnish to the CQSC and the hearing officer (a) a list of witnesses

expected to testify, (b) the documents expected to be introduced and (c) a statement as to whether the provider intends to be represented at the hearing by an attorney. The CQSC will furnish to the provider and the hearing officer a list of the documents it intends to introduce at the hearing no later than 10 days before the scheduled hearing. If the provider has indicated that he or she will be represented by an attorney at the hearing, the CQSC may choose to be represented by an attorney during the hearing. Each party will bear its own attorney costs.

5. If an issue arises about whether a party is allowing access to documents as provided in No. 3 above, the party requesting the access may ask the hearing officer to consider and rule on the request, keeping in mind the following considerations: (a) whether the requested document(s) is relevant to the action, (b) whether the request is unduly burdensome and (c) whether the requesting party has been fully cooperative.

Hearing Procedures

1. The hearing officer will record the hearing by using a recording device. The cost of any audio copy or written transcript prepared from the record will be borne by the party requesting the transcript.

2. The hearing officer will give each party a reasonable opportunity to present its case, call and examine witnesses, and call the other party as a witness and question him or her. However, the hearing officer may establish reasonable time limits on the presentation of each party.

3. The hearing will be conducted under informal rules of evidence. The rules of law relating to the examination of witnesses and presentation of evidence will not apply. Any relevant evidence, including hearsay, will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. The hearing officer may ask questions of the parties.

4. Generally, the burden of proof will be on the CQSC to show, by a preponderance of the evidence, that its decisions are supported by the facts. In the case of emergency suspension of practice rights, the burden is on the CQSC to demonstrate that an emergency suspension was necessary and that the issue(s) involved could not have been investigated in the normal course of an investigation.

5. Within 15 days after the hearing, the hearing officer will submit written findings and recommendations to the CQSC; the hearing officer may uphold the CQSC decision, reverse it or modify it. The director of Provider Network Management will send a copy to the provider, along with a statement that both the CQSC and the hearing officer's recommendations will be forwarded to the Pinnacol vice president with operational authority over the Provider Network

Management department for review and final action by the vice president's committee.

No Hearing

1. If the CQSC does not receive a written request for a hearing within the required period, the provider waives the right to the hearing and the CQSC decision will become final.
2. If the CQSC terminates the provider's agreement, the director of Provider Network Management will send notice to the PRS to remove the provider from the credentialing process (see Section 5 – Credentialing) and network provider database.
3. When applicable, the medical director will complete and submit a report to the NPDB and/or the appropriate licensing or other board.

Appeal to the Vice President's Committee

1. The vice president with operational authority over the Provider Network Management department will appoint an ad hoc committee of three Pinnacol executives to review the findings and recommendations of the hearing officer and the recommendation of the CQSC and any documents that support each determination. The vice president's committee may, if it deems necessary, request any further supporting materials for either determination.
2. The vice president's committee, upon majority vote, may approve, modify or reject the determinations of the hearing officer and/or the CQSC as it deems appropriate based on the facts.
3. The vice president's committee will forward its final decision to the CQSC. The director of Provider Network Management will send written notice of the final decision to the provider. If the final decision is termination of the provider's agreement, the director of Provider Network Management will send notice to the PRS to unlink the provider from the credentialing process and network provider database. When applicable, the medical director will complete and submit a report to the NPDB and/or the appropriate licensing or other board.

Standard for Professional Review

All participants in the professional review process will make recommendations or take actions in good faith (a) in the reasonable belief that the action was in the furtherance of quality health care; (b) after a reasonable effort to obtain the facts of the matter; (c) after adequate notice and hearing procedures or after such other procedures as are fair to the physician under the circumstances afforded to the physician; and (d) in the reasonable belief that the action was warranted by the facts known after such reasonable efforts to obtain facts through the hearing or other process.

Confidentiality of Professional Review
All parties and all participants in the professional review of quality of care concerns will maintain the confidentiality of the findings, recommendations and the proceedings. Pinnacol may, as it deems necessary, request that participants sign confidentiality agreements. It is intended that Section I of this policy will comply with the federal Health Care Quality Improvement Act and will provide immunity from all federal and state causes of action to the full extent of the law for the parties and the participants.

Effective Date
The effective date of any proposed disaffiliation or agreement termination will be tolled during the pendency of any of the steps in Section I.

II. Quality of Service Issues

Issues That Qualify as Quality of Service Concerns

The following issues, provided they do not involve quality of care concerns, qualify as quality of service concerns (the list is descriptive, not exhaustive):

- Failure to perform one or more of the obligations outlined in the network provider agreement (i.e., breach of the agreement) or the ***SelectNet*** Provider Manual;
- Failure to meet Pinnacol's communication standards;
- Failure to participate in the orientation program;
- Failure to notify Pinnacol of additions, changes or deletions in treating providers or clinic locations;
- Failure to maintain Pinnacol contractual administrative performance expectations;
- Failure to meet Pinnacol wait time expectations;
- Failure to timely verify, on request, an injured worker's inability to work; and
- Production of communications that are false or maliciously critical of Pinnacol and are calculated to injure Pinnacol.

(**Note**: The process in this section (Section II) applies to a group practice if the practice as a whole is subject to corrective or disciplinary action, or to a practitioner who is a participant in a group practice if the action applies only to that practitioner. For ease of reference, the term "provider" is used and can be construed as a practice or individual as applicable.)

Any ***SelectNet*** provider with five or more valid Provider Feedback Log entries, representing substantiated issues during the last credentialing cycle that are of varying or similar concerns, must be reviewed by the CQSC. A valid Provider Feedback Log entry occurs when a quality of service standard has not been met and is reported to and documented by Pinnacol's Provider Network Management team. All reported concerns must be documented. Determination that a reported concern is valid occurs only after Pinnacol gives an opportunity to the provider to offer feedback about

the reported concern. Should such feedback be received from the provider, the provider's response will be documented by Pinnacol's Provider Network Management team. Quality of service requirements are outlined in the provider's network agreement, the ***SelectNet*** Provider Manual and the ***SelectNet*** participation standards.

In addition, the CQSC may, in extraordinary circumstances based on the severity of any Provider Feedback Log entries that total any number fewer than five during the last credentialing cycle, consider a provider for review and further action if warranted.

In all cases, when a substantiated provider feedback log issue is determined to have occurred, the ***SelectNet*** provider will receive written notification from Pinnacol noting (1) the issue in question and the performance standard that was not met, (2) information related to how the particular issue was resolved, (3) the number of substantiated issues the provider has accumulated since his or her last credentialing cycle and the total number of issues permitted before a mandatory committee review ensues. The provider may submit a statement for entry into the log reflecting the provider's position on the issue or its resolution.

Investigation

1. An investigation will be conducted when the Provider Network Management team is informed of a potential quality of service concern. The Provider Network Management team may assign the investigation to the CQSC.
2. The CQSC will appoint a subcommittee to investigate, and the subcommittee may, at its reasonable discretion:
    - Meet informally and/or communicate in writing with the provider;
    - Collect relevant documentation;
    - Discuss issues with other persons having knowledge of the facts or conduct in question (providers authorize the release of such information by virtue of their network provider agreement);
    - Obtain independent review (e.g., from a physician advisor or other peer provider);
    - Analyze information to determine whether further action is warranted; and
    - Take any other steps consistent with the need to reasonably investigate the issue.

Determination

1. If the investigation reveals that further action is warranted, the subcommittee will present its findings to the full CQSC.
2. The CQSC will consider the investigative findings and decide whether to impose corrective or disciplinary action, including disaffiliation

(termination of the provider agreement); the decision regarding whether to take a particular action will be made by majority vote of the CQSC.

3. The CQSC will make best efforts to be consistent in the actions taken for like violations; however, the CQSC may take more severe action based on a provider's history of prior violations of quality of service standards.
4. The available disciplinary actions include but are not limited to:
   - Denial of renewal application;
   - Contract termination solely of the subject provider; and
   - Contract termination of the subject provider and any affiliated group.
5. Corrective actions that do not constitute disciplinary actions include but are not limited to:
   - Confidential letter of concern;
   - Corrective action plan; and
   - Shortened network affiliation period.
6. If the investigation reveals that no further action is warranted, the CQSC subcommittee will report this result to the full CQSC and answer any further questions from the CQSC.
7. If the CQSC determines that corrective action or disciplinary actions, including disaffiliation, will be imposed, the director of Provider Network Management will notify the provider of the action taken and of the quality of service concern that prompted the action. The letter will also inform the provider of its right to request, within 15 days, an informal meeting with the CQSC to discuss reconsideration of the action.

Informal Meeting

1. If the provider submits a timely written request for an informal meeting for reconsideration, the CQSC will itself hold (or assign a subcommittee to hold) the meeting within 15 days after the receipt of the written request for a meeting (unless otherwise agreed by the CQSC and the provider). The director of Provider Network Management will send to the provider, no later than 10 days before the meeting, written notice of the time, date, duration and place for the meeting.
2. The meeting is not a formal evidentiary hearing, but the provider may informally and briefly present reasons why the action should be reconsidered. The CQSC or subcommittee thereof may ask the provider any relevant questions and/or request additional information from the provider.
3. If the meeting is held by a subcommittee of the CQSC, the subcommittee will report its findings and recommendations to the full CQSC within five days after the meeting. The CQSC will, within 10 days after receipt of the recommendations, determine whether to affirm,

	modify or rescind its action. The director of Provider Network Management will notify the provider in writing of the CQSC decision. The action of the CQSC will be final. 4. The effective date of any proposed disaffiliation or agreement termination will be pending until the completion of the process provided in Section II.