



Pinnacol Assurance SelectNet[®] Provider Manual

Contents

Section 1: Pinnacol Assurance and SelectNet®

Introduction	1-1
About Pinnacol	1-1
SelectNet®	1-1

Section 2: Regulatory Requirements

Overview	2-1
When Is a Claim Compensable?	2-1
Claims for Mental Impairment without Physical Injury	2-1
Injury Reporting and Time Frames	2-2
Independent Medical Examinations	2-2
Provider Accreditation	2-3

Section 3: Provider Responsibilities and Case Management

Introduction	3-1
SelectNet® Case Management	3-1
Assessing Causality	3-2
Managing Disability	3-4
Educating Injured Workers	3-5
Communication with All Parties	3-6
Communication on Represented Claims	3-6
Scheduling and Wait Time	3-6
Referral Management Program	3-8
Use of Non-physician Practitioners	3-9
Maximum Medical Improvement (MMI)	3-10
Discharge from Medical Care Based on Noncompliance or Nonmedical Reasons	3-11
Permanent Impairment	3-11
Discharging Injured Workers from Care	3-12
Reopening a Claim	3-13

Section 4: Utilization Management

Medical Management	4-1
Pinnacol Assurance Utilization Management Program	4-1

Physician Advisor Program	4-2
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Section 5: Provider Responsibilities and Quality Management

Provider Initial Credentialing and Re-Credentialing Processes	5-1
Care Management Documentation Requirements for SelectNet Participants	5-2
Return to Work (RTW) and Modified Duty	5-2
Provider Orientation	5-3
Provider's Notification of Changes to Pinnacol	5-3
Employer/Client Management – PCPs	5-3
Quality Improvement Program	5-3
Billing	5-4

Section 6: Pinnacol's Responsibilities

Promoting SelectNet	6-1
Provider Communication	6-1
Network Management	6-2

Section 7: Appendices

Appendix A – SelectNet Participation Standards	7-1
Appendix B – Provider Assessment of Additional Need for Treatment after MMI	7-15
Appendix C – Claims Submission Instructions – CMS-1500	7-16
Appendix D – Quality of Care and Quality of Service Concerns and Process	7-17

Section 8: Glossary

Glossary of Terms	8-1
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This manual was developed by Pinnacol Assurance and is intended solely for the use of Pinnacol Assurance and Pinnacol Assurance's preferred provider network, SelectNet. It is provided with the understanding that Pinnacol Assurance is not engaged in rendering legal, accounting, or other professional services. If legal advice or other expert assistance is required, the services of a competent professional should be sought. Nothing in this manual is intended to direct medical care. Providers are expected to exercise their independent medical judgment.

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Pinnacle 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.
- Define key requirements and responsibilities of SelectNet providers
- 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 53,000 policyholders throughout the state. Our vision is to lead a revolution in caring for the people, businesses and communities of Colorado.

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, medical case managers, safety services and return-to-work consultants. 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 physicians
- Specialist physicians

- Acupuncture
- Behavioral health professionals
- Chiropractic care
- Diagnostic and laboratory services
- Durable medical equipment
- Home health care
- Inpatient and outpatient hospitals and facilities
- Massage therapy
- Nurse practitioners
- Orthotics and prosthetics
- Pharmacies
- Physical, occupational, and speech therapy
- Physician assistants
- Psychiatrists, psychologists
- Skilled nursing facilities
- Urgent care clinics



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:

<https://cdle.colorado.gov/workers-compensation-rules-of-procedure>

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.

The question of whether an injury arose out of and in the course of employment is one fact to be determined by an examination of all the relevant circumstances. The terms "in the course of" and "arising out of" are not synonymous. The "course of employment" requirement is satisfied when it is shown that the injury occurred within the time and place limits of the employment relationship and during an activity that had some connection with the employee's job-related functions. An injury "arises out of" employment when it has its origin in an employee's work-related functions and is sufficiently causally related to those functions to be considered part of employment.

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 website for the current requirements for:

- Injured workers reporting injuries to their employers
- Injured workers reporting occupational diseases to their employers
- Employers reporting 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 resolve 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.” Division IMEs are coordinated through the DOWC and are performed independently of any contract between Pinnacol and a provider. Division IMEs are paid at the rate set by the DOWC without a PPO discount applied. Division IMEs are generally paid for 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 resolve causality or other medical and/or legal issues. Typically, the payer requests this type of IME and has chosen the examiner. The IME report should be served concurrently to all parties no later than 20 days after the examination. The findings of non-Division IMEs are not binding and will be paid at the rate set by the DOWC without a PPO discount applied. Questions regarding a non-Division IME should be directed to the requesting party.

Provider 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 accreditations: Level I and Level II.

Level I Accreditation

Level I Accreditation is available for MDs, DOs, chiropractors, dentists, podiatrists, physician assistants, and nurse practitioners with prescriptive authority. Although only these types of medical providers can be accredited, any medical provider can take the course. Under Colorado law, Level I-accredited physicians are not allowed to provide impairment ratings except for determining that no impairment exists. Additionally, chiropractors are limited in treatment they can provide to patients, unless they are Level I accredited. Pinnacol Assurance offers a [Workers’ Compensation Basics for Providers](#) course to orient providers and clinic staff about the treatment of injured workers in Colorado’s workers’ compensation system. This course is free and all network providers are encouraged to complete it.

Level II Accreditation

Level II Accreditation was established under Colorado law for providers who perform impairment ratings, 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. Level II Accreditation is available

through the DOWC. 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 303.318.8754, or by accessing the [DOWC website](#). Information about the Pinnacol Assurance Workers' Compensation Basics for Providers course can be obtained by accessing the Pinnacol's provider [training website](#) or by calling Pinnacol's Provider Relations at 303.361.4945.



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 with 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 occupational health primary care provider (PCP) is the designated provider for an injured worker and fulfills a multifaceted role. Typically, the occupational health PCP is responsible for:

- 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
- 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. 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 a claims representative or, if compensability is disputed, 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 it.

The necessary causal connection between the worker's medical condition and an event (or exposure) at work should 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 should not be properly ascribed to the employee's work.

The initial causality determination requires an assessment of medical probability. It is necessary that all 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
- 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 injured worker's job duties
- Exposure to hazards on the job
- The injured 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
- Additional information from Pinnacol or the injured worker's employer

The PCP should then determine whether a workplace factor is:

- The only cause
- One of several contributing causes
- 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. 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 should 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 should 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 should also be assessed in instances in which a subsequent medical condition develops in conjunction with a work-related injury. If this occurs, the PCP should 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 should 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 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. 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 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 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 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
- Off-duty status

Most Pinnacol claims are medical only or non-lost-time claims, meaning the injured worker misses fewer than three work shifts. The remainder 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 with 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 an injured 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 (RTW) consultant who works directly with employers to assist them in providing modified duties in difficult employment situations. RTW consultants will have discussions with the employer and the injured worker to facilitate modified duty while keeping providers in the loop throughout the process. Returning an injured worker to modified duty can aid recovery and improve outcomes for both injured workers and employers. To start the RTW process, providers can reach Pinnacol's RTW Specialist at 303.361.4798 or make a request for RTW assistance through Pinnacol's [Provider Portal](#).

It is extremely important that the PCP defines 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 an injured worker's return to modified duty. With specific restrictions, such as the maximum weight the injured worker can lift or the period the injured 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 most of an injured worker's care, the PCP should work with the specialist to determine the appropriate restrictions for the injured worker. Since it is important to update restrictions often, the PCP should reevaluate the injured worker on a regular basis and communicate regularly with the specialist to determine if restrictions should be updated. Restrictions provided by the specialist and PCP should be the same; when they are not, this can cause delays in return to work and confusion for all stakeholders.

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 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. The PCP should do this as early as possible during the claim and repeatedly thereafter, helping IWs understand the meaning of key concepts including maximum medical improvement, the therapeutic value of modified duty return-to-work, and an emphasis on functional improvement over the complete resolution of pain.

It is important for the PCP to outline what the injured worker can expect and to define the worker's responsibilities in 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 should include the claim number. Pinnacol's medical case manager and claims representative assignments can be found by logging in to Pinnacol's [Provider Portal](#) or calling customer experience at 303.361.4000.

At all times and for all open claims, Pinnacol's claims management team should have access to the PCP's documented, current treatment plan, 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.

Communication on Represented Claims

Ex parte communications occur when an injured worker is represented by an attorney. Ex parte means one party of the claim contacts another party of the claim without that party's attorney being present.

There is no statute, rule or case law that limits ex parte communications simply because an injured worker is represented. Since the doctor-patient privilege has been waived by the filing of a claim, the claims representative or medical case manager working on a claim may engage in ex parte communications with providers about medical information that relates to the work injury or any medical condition that contributes to the need for medical treatment in the claim.

The Act requires any treating physician who communicates with the employer or insurer outside the presence of the injured worker or injured worker's attorney to capture, in writing, the relevant and material information of the communication and to provide the injured worker with access to the writing in the same manner as other medical record disclosures. This does not apply to office personnel or staff communications when the subject is scheduling, billing, or other administrative issues.

Scheduling and Wait Time

Most 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 times are minimized.

Primary Care Clinics

- Clinics should have provisions for in-person walk-in/urgent care evaluations for injured workers during standard business hours (Monday-Friday over at least an 8-hour period each day)
- 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 On-Call Provider Policy referenced later in this section.

- Office wait time for scheduled appointments should not exceed 30 minutes.
- Clinics should 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 or clinic cancels or reschedules an appointment, the PCP should notify Pinnacol within 2 business days.
- In cases where the injured worker does not attend a scheduled appointment, the PCP should:
 - Provide written notification (email, letter, WC164 Form, or medical record) within one business day. Notification must include the injured worker's name and claim number, appointment date, clinic and provider name, and a clear no-show statement.
 - 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 (also referred to as a payer made appointment), if the injured worker cannot be contacted.

Note: Neither the injured worker nor clinic should reschedule a demand appointment. If an appointment needs to be changed or canceled, the claims representative should be notified immediately. If the claims representative agrees to schedule a demand appointment, the appointment should be scheduled with a physician and not a mid-level practitioner.

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 should 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 or surgery has been made, the specialist should make best efforts to perform non-emergency surgery within 10 business days. 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 SelectNet 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 should 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 visiting <https://provider.pinnacol.com/> and clicking on "Provider Directory" at the top of the screen.

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 should 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 with a copy of the referral and any pertinent medical information necessary to ensure the initial specialist appointment.

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, Pinnacol will pay for the in-house dispensing of prescription or over the counter (OTC) medications only in emergent situations involving a threat to an injured worker's life or health where immediate in-house dispensing is required to meaningfully mitigate the threat. In these circumstances, Pinnacol will pay for no more than a 14-day supply of dispensed medication. Pinnacol may request documentation and obtain an independent medical review to determine whether an emergent situation existed.

Payment may be denied after a medication has been dispensed if it is determined that an emergent situation did not exist. Beyond the initial 14-day emergency supply, for all other situations, medications should be supplied by a registered pharmacy in Pinnacol's pharmacy benefit manager program (PBM). All prescriptions should continue to be filled with bioequivalent generic drugs unless medically contraindicated.

In accordance with the DOWC Rule 18, prior authorization for prescriptions is required for:

- Any medication "not recommended" in DOWC Rule 17, Medical Treatment Guidelines, for a particular diagnosis

- Any non-steroidal anti-inflammatory drug (NSAID), muscle relaxant, or topical agent for which a significantly lower-cost therapeutic equivalent is available, including commercial or OTC, even in different strength/dosage. Significantly lower cost means the therapeutic equivalent costs at least \$100 less, for the same number of days' supply.

In part, this policy helps to address ongoing concerns related to patient opioid abuse, whether inadvertently or purposefully. It also helps to address concerning trends related to the inappropriate prescribing and dispensing of high-cost topical and other medications when lower-cost, similarly effective alternatives are available. When an injured worker fills a prescription through Pinnacle's PBM, monitoring for contraindicative medications and medication abuse occurs, resulting in reduced risk of adverse reaction or abuse.

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.
- 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."

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 in the PCP's independent medical judgment, the use of an out-of-network provider is necessary.

Use of Non-physician 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 should maintain ongoing care coordination, including:

- Reviewing and co-signing medical records related to the injured worker's inability to work resulting from the work injury or disease
- Reviewing and co-signing medical records related to the injured worker's ability to return to regular or modified employment

- Completing and signing return-to-work task letters
- Determining when an injured worker reaches MMI
- 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 or NP 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.
- NPs with prescriptive authority must maintain a formal collaborative agreement with a Colorado licensed physician outlining their respective duties.
- Per DOWC Rule 16, a physician must evaluate an injured worker when:
 - A treating PA or NP recommends it.
 - Deemed necessary by a physician.
 - Requested by the injured worker or payer.

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

Maximum Medical Improvement (MMI)

According to 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 the 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)].

The SelectNet PCP is the appropriate physician to render an opinion on MMI. If an injured worker meets the definition of MMI, then an MMI determination should not be delayed for any reason, including the injured worker’s job status.

Once it is determined that an injured worker has reached MMI, the claims management team must address whether, 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.

Discharge from Medical Care Based on Noncompliance or Nonmedical Reasons

An authorized treating provider (ATP) may discharge an injured worker from medical care in 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 of 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.

Injured workers who dispute a finding of MMI can request a Division IME from the DOWC. The finding of the Division IME physician regarding MMI is binding, except when overcome by clear and convincing evidence.

At times, the claims management team may request a Division IME. This typically occurs when more than 24 months have elapsed since the date of injury without an ATP placing the injured worker at MMI, and a non-Division IME physician has examined the injured worker and opined that the injured worker is 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 to the Evaluation of Permanent Impairment. The DOWC may not impose requirements contrary to those of the AMA Guides.

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 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 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. If the PCP is not Level II accredited and has determined the injured worker has reached MMI and sustained a permanent impairment, the PCP shall refer the injured worker to a Level II accredited physician to complete the IR within 20 days after the determination of MMI. If the PCP has trouble locating a Level II

accredited physician to refer an injured worker to, the PCP should contact the injured worker's claims representative to request assistance in locating a Level II accredited physician.

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 Level II-accredited 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 any delay 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 a SelectNet provider who has not previously treated the injured worker, the SelectNet standard for the acceptable period between the statement of MMI and receipt of the rating by the claims management team is 30 calendar days from the date of the referral. If the referred provider has previously evaluated or treated the injured worker, the rating should be received within 14 calendar days from the date of the PCP 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 of Procedure.

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 about 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 should specify the maintenance care required when permanent impairment is determined. The treatment or medication should be reasonable, necessary and related to the injury. On the WC164 Form, the PCP should 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 should first call the claims team to obtain authorization for payment 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 of payment for treatment.

Rescinding MMI

With few exceptions, only the physician who placed the worker at MMI can rescind MMI. 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 MMI 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 the appropriate appeals process when payment authorization 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 Act [C.R.S. 8-40-101, et seq.] and Rules of Procedure (Rules 16, 17, & 18) adopted by the DOWC. The Act and the Rules of Procedure can be found at <https://cdle.colorado.gov/statute-rules-guidance>. The components of this program are the prior authorization for payment request process and Pinnacol's physician advisor program.

Prior Authorization

Except in emergent situations, for purposes of authorized payment by Pinnacol, clinics should verify the claim is open, active and eligible for medical benefits before rendering treatment or making referrals for other services. Prior authorization for payment is not necessary for diagnostic testing, in-network referrals or treatments when consistent with the Medical Treatment Guidelines (MTG) issued by the DOWC. Please refer to the DOWC website for additional information. According to DOWC Rule 16, prior authorization for payment is required when:

- A prescribed treatment exceeds the recommended limitations set forth in the MTG.
- The MTGs require prior authorization for that specific service.
- A prescribed treatment is not priced in the Medical Fee Schedule or is identified in Rule as requiring prior authorization for payment.

Requests for prior authorization should include:

- An explanation of the reasonableness and medical necessity of the requested treatment
- Relevant supporting documentation
- An adequate definition or description of nature, extent and necessity for the treatment
- Identification of the appropriate MTGs, if applicable
- Final diagnosis

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

Acceptance of prior authorization requests will be provided by phone or in writing within 10 days of receipt of the provider's complete request.

Denial of prior authorization requests will be provided in writing to all parties within 10 days from receipt of the provider's complete request.

Pinnacol may also issue retrospective denials. This means that all services rendered without prior authorization are subject to a review after the fact to determine medical necessity and reasonableness. Services that do not meet these standards based on an independent review may be subject to payment denial.

Physician Advisor Program

Pinnacol's physician advisor program, established in 1997, is staffed by Colorado physicians of diverse specialties. The program complies with DOWC Rule 16, which requires that physician advisors 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 physician advisor is to provide guidance and advice, consistent with the MTGs and current evidence-based medical literature, to Pinnacol's claims and case management staff. The physician advisor conducts an independent review related to the specific treatment request and then completes a written summary of his or her recommendation.

When the physician advisor asserts that the requested service is necessary and appropriate, the medical case manager will promptly authorize payment for the requested service and will notify the requesting provider by phone within 10 days from receipt of the provider's completed request. The medical case manager will also notify all parties in writing.

When the physician advisor recommends denial of a request, he or she will provide a written medical opinion to support the denial. A written denial of payment, including the physician advisor's medical opinion, name and professional credentials, will be mailed to all parties within 10 days from receipt of the provider's complete request.

Disputes regarding prior authorization decisions will be resolved according to the processes outlined in DOWC 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 must be approved by Pinnacol Assurance and complete the credentialing process before providing health care services to injured workers pursuant to a SelectNet® contract. Practitioners requesting SelectNet affiliation are required to meet Pinnacol's minimum credentialing requirements.

To begin the credentialing process, the practitioner must submit to credentialing@pinnacol.com the practitioner's Council for Affordable Quality Healthcare (CAQH) ID number, the completed provider disclosure form, group participation affiliation form, and a list of the clinic locations where he or she is affiliated. Credentialing forms can also be obtained through Pinnacol's [Provider Portal](#) but must be emailed to credentialing@pinnacol.com.

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 three years in most cases.

Re-Credentialing

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

In cases of re-credentialing, the practitioner must keep his or her profile, including attestation and all credentialing related documents, current with CAQH. If the practitioner's profile is not current at the time of the CVO re-credentialing verification process, the CVO will fail the file and notify Pinnacol Assurance. To avoid removal from the network directory and disaffiliation from SelectNet, the practitioner should make his or her CAQH profile current within 30 days of notification by either the CVO or Pinnacol Assurance.

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.

Hospitalists, Radiology and Rehab Service Providers

Hospitalists, radiology and rehab service providers have delegated credentialing verification responsibilities and shall verify that each group participant meets Pinnacol's SelectNet credentialing standards as listed in Exhibit B of the SelectNet Agreement. At its sole discretion, Pinnacol may audit the provider's credentialing activities as they relate to SelectNet participation 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 should provide the following components:

- Mechanism of injury
- Causality assessment (if appropriate)
- Current condition of the 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 PCP
- When return-to-work is anticipated
- Anticipated MMI date as assigned by the PCP
- 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:

- 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")
- 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 Rule 6 offers of modified employment (often referred to as a task letter), the PCP should respond within two business days of receipt. The letter should 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 DOWC's Rules of Procedure. This required orientation is normally completed during an in-person visit from the provider relations specialist (PRS) assigned to the clinic within the first three months of joining SelectNet. In addition to the provider orientation, SelectNet participants and their staff shall meet with their assigned PRS when requested or with Pinnacol's Senior Medical Director.

Provider's Notification of Changes to Pinnacol

SelectNet providers are required to notify Pinnacol's Provider Network Management department 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 – PCPs

Pinnacol recommends that PCPs establish relationships and outline service expectations with their employer designators. Designation reports are available via the Pinnacol [Provider Portal](#).

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

As part of the SelectNet agreement, participants will not, directly or indirectly, (i) induce or encourage any insured of Pinnacol Assurance to terminate or not renew such insured's workers' compensation policy with Pinnacol Assurance or otherwise divert their business away from Pinnacol Assurance or terminate their relations with Pinnacol Assurance, or (ii) make any negative or disparaging statements regarding Pinnacol Assurance and its business, including any inaccurate, false or misleading statements regarding Pinnacol Assurance's programs, policies, benefits or rates or any statements suggesting Pinnacol Assurance's competitors offer superior programs, policies, benefits or rates.

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. Pinnacol expects providers to make themselves available to receive this feedback and to take it seriously. 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 the DOWC Rules 16 and 18. All SelectNet participants (including providers and ancillary vendors) who meet the DOWC 25-bill-per-month volume threshold for bills are required to submit all bills electronically. Pinnacol enforces this requirement for all SelectNet services.

Regardless of the type of provider, all providers must bill under their own name, credentials, and NPI when billing on a CMS-1500, Dental Claim Form, or UB-04. Billing under a supervising physician or any other provider's credentials is not permitted. 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, and a pattern of improper billing may be reported to regulatory authorities and result in termination from SelectNet.

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 to treat a work injury.

Providers should redact Social Security numbers on all medical bills. 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. To check the status of previously submitted bills, log into Pinnacol's provider portal.

DOWC Medical Fee Schedule

Pinnacol reimburses at rates established by the Colorado DOWC Rule 18, Medical Fee Schedule, less any applicable contractual discount in effect at the time services are rendered. DOWC Rule 18-1 identifies the current editions of publications to be referenced for billing codes and can be accessed at the DOWC website. If a fee schedule is not established, network participants should refer to their current SelectNet Agreement for applicable reimbursement rates.

Electronic Billing

Pinnacol strongly encourages electronic billing, and in some cases may require this format. Pinnacol works with the following electronic transaction clearinghouses:

Carisk Intelligent Clearinghouse:

- Phone number: 973.795.1641, option 2
- Pinnacol payer ID: E4050
- Email: cicsales@cariskpartners.com
- <https://www.cariskic.com/Signup.aspx>

Data Dimensions Clearinghouse:

- Phone number: 800.297.6909
- Pinnacol payer ID number: CB746
- Email: info@datadimensions.com
- <https://datadimensions.com/pinnacol-assurance/>

For providers not yet billing electronically, it's recommended to register with one of Pinnacol's preferred clearinghouses. Moving to an electronic format not only ensures compliance with DOWC Rule 16 but also facilitates faster reimbursement. Additionally, utilizing one of Pinnacol's preferred clearinghouses allows providers to take advantage of integrated medical record submission, ensuring that all necessary documentation is delivered simultaneously with the bill.

Paper Billing

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

1. Centers for Medicare & Medicaid Services (CMS)-1500 – used by all providers billing for professional services, durable medical equipment (DME), home health and ambulance except for 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 – used by all hospitals, hospital-based ambulance/air services, children's hospitals, critical access hospitals, veterans' administration facilities, and facilities meeting the definitions found in DOWC 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 2019 – 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 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 claim number for the case being billed. Field #76 (Attending Physician) 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. 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:

Pinnacol Assurance
PO Box 4155
Clinton, IA 52733-4155
Fax: 720.403.9007
Email: pinnacolbillsubmissions@ddinboundsecure.com

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
- Pinnacol's client (the policyholder) has designated the SelectNet provider and has sent the injured worker to the provider.

Reconsideration

Explanation of benefits (EOB) or explanation of remittance (EOR) 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 Pinnacol [Provider Portal](#). 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 or EOR. Rebills requiring additional documentation can be faxed to 720.403.9007, Attention: Medical Payments Team.

Appeals

Per DOWC Rule 16, the billing provider has 60 days to respond to the payer's written notice to contest. If a response is not received in this time frame, the bill will not be considered for appeal. The process for payer and online appeals is provided on the Pinnacol [website](#).



Pinnacle'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 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 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 non-Division IMEs. The claims management teams educate employers on the benefits of using the network and of designating SelectNet PCPs.

SelectNet Directory

The public can access the SelectNet Directory by visiting Pinnacol's provider website at www.provider.pinnacol.com and clicking "Provider Directory" from the top menu. Pinnacol's policyholders can designate SelectNet providers from the online directory, which defaults to showing designated providers and is also accessible via Pinnacol's main website, Pinnacol.com.

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 are available to assist with questions or issues related to individual SelectNet Agreements. As a rule, communication regarding a specific injured worker should be directed to the appropriate claims management team; however, the PRS staff are available to assist with any challenges that may arise. Pinnacol's PRS staff may be reached at 303.361.4945 or provider_management@pinnacol.com.

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
- 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 or operationally focused and presented by experts in the field of workers' compensation.

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.

Provider Updates

Updates to SelectNet policies and procedures and Colorado regulatory requirements, as well as discussions of relevant medical topics, are emailed periodically. Current email addresses must be on file with Pinnacol's Provider Network Management department to receive these updates. Emails can be updated by contacting 303.361.4945 or provider_management@pinnacol.com.

Employer Designation Reports for Primary Care Providers (PCPs)

SelectNet PCPs have online access to employer designation reports. These reports provide a contact phone number 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 with experience in the workers' compensation system. Pinnacol staff members who serve on the CQSC may include:

- Senior Medical Director (chair)
- Director of Provider Network Management
- Healthcare Contract Specialist
- Business Director
- Medical Case Management Director
- Claims Representative(s)

A member of Pinnacol Assurance's legal department 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)
- Director of Provider Network Management
- Healthcare Contract Specialist
- 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 department uses a formal process to admit providers and approve contracts into SelectNet and, when necessary, to disaffiliate them from the network. CQSC and NAC are often involved in this process. For specific information related to the policies and processes used to address such issues, please review Appendix D.

Network Performance

The Provider Network Management department monitors SelectNet clinic and provider performance:

- Performance profiling
- Provider disputes/grievances/complaints/recognition information
- Provider feedback loop

Performance Profiling Overview

Pinnacol produces performance reports for SelectNet primary care, physiatry, physical therapy, and other kinds of clinics. These reports include utilization and cost data benchmarked against aggregate SelectNet performance.

Eligible SelectNet providers can request a copy of their profiling reports by logging in to the Pinnacol [Provider Portal](#) by subscribing to the Profiling report located under the Request Reports tab. 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
- Billing and reimbursement

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

Provider Feedback Tracking System

Pinnacol's Provider Network Management department 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.

Feedback for clinic or ancillary service vendors is tracked during a rolling 24-month period. Every clinic or vendor will be allowed at least 5 substantiated negative provider feedback loops (FBLs) in a rolling 24-month period before the clinic or vendor is referred to CQSC for review. Above this amount, the allowable total number of negative FBLs for each clinic or ancillary service vendor over the rolling 24-month period will depend on the volume of services the clinic or ancillary service vendor provides to Pinnacol injured workers (reflected by bill count). In situations deemed egregious in nature, a clinic or ancillary service vendor may be presented to the CQSC with fewer than five valid FBLs.

Providers receiving five valid FBLs within a credentialing cycle will be presented to the CQSC for review and possible disciplinary action. In situations deemed egregious in nature, a provider may be presented to the CQSC with fewer than five valid FBLs. Please see Appendix D for more information on the process used to address quality of service or quality of care concerns.



Appendices

Section 7

Appendix A – SelectNet[®] Participation Standards

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. Providers are expected to exercise their independent medical judgment.

All SelectNet participants are expected to act professionally at all times. Professional conduct is a combination of attitude, appearance, and manners. This includes how a SelectNet participant speaks, looks, acts and makes decisions. Examples of professional conduct are listed below (the list is descriptive, not exhaustive):

- Treating Pinnacol's employees, injured workers, and policyholders with respect
- Being courteous towards Pinnacol's employees, injured workers, and policyholders
- Behaving with integrity
- Showing appropriate tone, body language, and dress for a professional environment
- Projecting a positive attitude

PCP Participation Standards

Pinnacol considers PCPs the heart of SelectNet. Pinnacol expects PCPs to:

- Thoroughly evaluate, treat and educate the injured worker.
- 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.
- Render longitudinal care for injured workers the PCP begins to treat as the injured worker's designated provider. Only under rare circumstances and following consultation with Pinnacol's claims management team should the PCP transfer patients to another clinic for ongoing care. This standard applies even if the alternative PCP is a clinic in the same corporate entity or if the treating medical provider works at both locations.

Case Management

The PCP is responsible for:

- Determining causality
- Coordinating referrals for further evaluation and treatment
- Monitoring functional gains and progress until MMI is reached
- Determining physical restrictions, and clearly communicating the restrictions to all parties to the claim
- Determining MMI and permanent impairment (if any) and discharging the patient from care

Communication with Pinnacol

The PCP should:

- Return calls and emails to Pinnacol within two business days.
- Respond to written requests for Rule 6 or modified duty (task letter) 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 WC164 Form to Pinnacol so that it is received within three business days from the date of service.
- Provide medical records and legible office visit notes, including the provider's signature and/ or printed name, to Pinnacol so that they are received within seven business days from the date of service. Medical records and notes should include:
 - Mechanism of injury
 - Causality assessment (initial and closing visits)
 - Current condition of injured worker
 - Diagnosis
 - Treatment plan
 - Medications
 - Specific work restrictions
- Provide documentation to Pinnacol upon determination of MMI. Although the maximum time to return reports is listed below, rapid submission of documentation may avoid delay of the injured worker's return to work and claim resolution.
 - **Claims with no impairment:** A narrative report must be submitted with a physician signature and include the date of MMI. It should also address if there are any applicable permanent restrictions and maintenance care. A statement regarding whether there is impairment should be included. The narrative report must be received within seven calendar days from the date of MMI.
 - **Claims with impairment:** A narrative report must be submitted with a physician signature and include the date of MMI. It should also address if there are any applicable permanent restrictions and maintenance care. The narrative report should identify the injured worker's permanent impairment. The IR worksheet should be sent with the narrative report. All documentation should be received within 14 calendar days from the date of MMI.
 - If the impairment rating is referred to another SelectNet provider who has not previously treated the injured worker, the acceptable time frame between MMI and receipt of the narrative report and worksheet by the Pinnacol claims staff is 30 calendar days from the date of the IR referral.
 - Regardless of if there is impairment, a closing WC164 Form that addresses sections 5, 6 B-C, 7 (if applicable), and 8-11 is encouraged to be completed and sent to Pinnacol with the narrative report.
 - If a closing WC164 Form is submitted to Pinnacol, the information in the closing WC164 Form should match the information in the narrative report.

- If a full duty release is provided prior to the determination of MMI, send records to Pinnacol within seven business days of the date of service. The employer should also be notified as quickly as possible.
- Respond in writing by fax, mail, or email to any other written correspondence from Pinnacol or its representative so that it is received within 10 business days from the date of correspondence. Examples include, but are not limited to, letters sent to a provider regarding an injured worker's treatment plan or requests to view video surveillance and respond to questions related to the video.
- Provide notification to the claims management team of any no-shows for appointments within one business day. Written notification can include a medical record, WC164 Form, email, or letter. Information that needs to be included in the notification:
 - Injured work's name and claim number
 - Date of the scheduled appointment
 - Clinic name
 - Provider name
 - A clear statement the injured worker did not show for the scheduled appointment
- Provide notification to the claims management team of any canceled or rescheduled appointments that are not demand appointments, within 2 business days.

Wait Times and Availability

- The wait time for scheduled appointments should not exceed 30 minutes.
- The 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.
- Healthcare services should be available Monday through Friday during normal business hours.
- For rural or frontier providers health care services should be available in a manner that adequately addresses community needs. A rural area means a county outside the Metropolitan Statistical Area (MSA), or a health professional shortage area located either outside the MSA or in a rural census tract, as determined by the Office of Rural Health Policy, Health Resources and Services Administration, United States Department of Health and Human Services.

PCP Referrals

- The PCP should initiate all referrals and schedule initial appointments for the injured worker.
- The PCP should make a referral to a SelectNet specialist within two business days from the date the need for specialist treatment is identified.
- Referrals should be to SelectNet providers, unless the service is not available within the network or if in the PCP's independent medical judgment, the use of an out-of-network provider is necessary.
- Pinnacol should be advised before the PCP makes any out-of-network referral.

Urgent Care Participation Standards

SelectNet urgent care providers should offer only immediate, urgent care and follow-up care should be provided by one of the employer's chosen workers' compensation designated providers.

Note: Follow-up for suture removal is permitted if no other follow-up is needed.

In the absence of a genuine emergency, urgent care providers should not refer injured workers to specialists. All non-emergent specialty referrals should be made by the designated provider selected by the injured worker from the employer's list of designated providers. The DOWC authorizes Pinnacol to deny payment for any completed referrals that were not generated by an authorized treating provider. All urgent care facilities must be accredited or certified by the Urgent Care Association (UCA) or accredited by the Joint Commission to be recognized for a separate facility payment for the initial visit per DOWC Rule 18.

Communication with Pinnacol

The urgent care provider should:

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

Wait Times

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

Urgent Care Provider Referrals

- Following the initial treatment, the urgent care provider should immediately refer the injured worker to the employer for a list of designated providers.
- When possible, the urgent care provider should call the employer to verify employment, advise of treatment, and have the employer provide the designated provider list to the employee for follow-up care.
- Referrals should be to SelectNet providers, unless the service is not available within the network or if in the urgent care provider's independent medical judgment, the use of an out-of-network provider is necessary.
- Pinnacol should be advised whenever the urgent care provider needs to make an out-of-network referral.

Specialist Participation Standards

SelectNet specialists coordinate care with the PCP to ensure injured workers receive medically necessary and timely care. SelectNet specialists are expected to follow DOWC Rule 17, MTGs 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 are responsible 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.

If an injured worker requires hospital admission and/or surgery, then the on-call provider may admit and/or perform the necessary surgery, subject to the limitations and conditions of the SelectNet 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, then the on-call provider should transfer case responsibility to the in-network group participant or the PCP, whichever is appropriate, for follow-up care.

Scheduling

The specialist should:

- Schedule appointments within 24 hours of referral.
- Evaluate/treat the injured worker within five business days from the date of the referral.
- Perform elective surgery within 10 business days of receiving authorization for payment of the 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. The specialist should also meet all other PCP performance standard expectations outlined earlier in Appendix A.
- Referrals should be made to SelectNet providers, unless the service is not available within the network or if in the specialist's independent medical judgment, the use of an out-of-network provider is necessary.

- Pinnacol should 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, should be referred to the employer's designated provider choice for workers' compensation care.

Procedures

The specialist practice should schedule and perform only those procedures specifically requested in the referral. For procedures requiring prior authorization for payment according to DOWC Rule 16, Utilization Standards, Pinnacol's approval must be obtained before scheduled and performed. The specialist practice should perform elective surgery within 10 business days of receiving authorization for payment from Pinnacol. When scheduling an assistant surgeon, best efforts should 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 should communicate directly with the PCP and the Pinnacol claims management team within 24 hours of the 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 should include:

- Treatment plan
- Medications
- Date of next appointment (if appropriate)
- Causality assessment (required only when the specialist has assumed the PCP role).

For Ongoing Care

The specialist practice should re-evaluate the treatment plan after each major procedure or series of injections. After each re-evaluation, the specialist should provide updated treatment information to both the referring PCP and Pinnacol. All updated information should be submitted within seven business days from the date of the re-evaluation. Information on any follow-up narrative reports should include:

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

Postoperative Care and Case Closure

The PCP and the specialist should 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 should:

- Notify the claims management team within one business day if an injured worker misses an appointment.
- Return calls and emails to Pinnacol within two business days.
- Respond in writing by fax, mail, or email to any written correspondence from Pinnacol or its representatives that it is received within 10 business days from the date of correspondence. Examples include, but are not limited to, letters to a provider regarding an injured worker's treatment plan or requests to view video surveillance and respond to questions related to the video.
- Respond to the written Rule 6 offer of modified duty (task letter) within two business days.

Rehab Service Provider Participation Standards

Rehab service providers include physical therapists, occupational therapists, speech therapists, massage therapists and acupuncturists. Rehab service providers should adhere to the following network participation standards, requirements and conditions in addition to all applicable specialist participation standards listed above.

The rehab service provider should:

- Only treat injured workers covered by Pinnacol with a current prescription from the referring physician.
- Begin prescribed services within two working days of the referral.
- Provide written reports to the referring provider within five days of service. This includes initial, progress, and discharge reports.
- Obtain prior authorization for payment from Pinnacol before providing any job site analysis services.
- Obtain prior authorization for payment 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 test to the referring provider and Pinnacol within seven days from date of service.
- Obtain prior authorization for payment from Pinnacol if a prescribed service exceeds recommended limitations as set forth in the DOWC's MTGs.
- Document and communicate any requests for additional services to the referring provider responsible for managing the injured worker's care.
- Send therapy notes to the referring physician.

Psychological Service 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 providers should 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 should include:

- Mechanism of injury
- Causality assessment
- Current condition of injured worker
- Diagnosis
- Treatment plan
- Medications
- Date of next appointment (if applicable)

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

Information on any follow-up narrative report should include:

- Current condition of the injured worker
- Diagnosis
- Treatment plan
- Medications
- Date of next appointment (if applicable)

Because the PCP is responsible for managing an injured worker's care, the psychological services provider should not establish physical restrictions or place an injured worker at MMI. The PCP should be consulted and concur with any treatment plans initiated by the psychological services provider. The psychological services provider must obtain prior authorization for payment from Pinnacol before performing services not specifically addressed in DOWC Rule 17, MTGs, or that exceed the limits as outlined in the treatment guidelines, or require prior authorization, as stated in the treatment guidelines.

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 may utilize the services of a Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT) or

Licensed Professional Counselor (LPC) who is recognized under DOWC Rule 16 and is registered or licensed by Colorado's Department of Regulatory Agencies.

- LCSWs, LMFTs and LPCs should receive referrals from an authorized PCP or credentialed mental health professional (a psychologist or psychiatrist) only after a formal psychosocial assessment with a specified mental health diagnosis and a recommended treatment plan consistent with the MTGs has been done.
- After receiving a referral, LCSWs, LMFTs and LPCs should initiate and carry out the recommended treatment plan within five business days after receiving the referral.
- If LCSWs, LMFTs or LPCs believe an injured worker is not making sufficient progress based on the recommended treatment plan, and modifications to the treatment plan are clinically indicated, the LCSW, LMFT or LPC should communicate with the credentialed mental health professional who established the treatment plan to revise the plan. Prior authorization for payment must be obtained from Pinnacol.
- Prior authorization for payment of therapy outside the MTGs must be obtained from Pinnacol.
- Therapy notes, including notations related to measurable progress towards objective goals, should be sent to the psychiatric physician within seven days of each therapy session.

Interpreter Participation Standards

- All contracted interpreters will meet the DOWC's certification requirements.
- Spanish-speaking interpreters must have certification from one of the two approved national certification agencies identified by the DOWC.
- Contracted interpretation agencies will not use an interpreter who has their own direct contract with Pinnacol.

Communication with Pinnacol

The interpreter vendor should:

- Return calls and emails to Pinnacol within two business days.
- Respond in writing by fax, mail or email to written correspondence from Pinnacol or its representative within ten business days.
- Provide notification to the claims management team when an injured worker does not show for an appointment within one business day.

Billing

- Invoices should use the DOWC's billing codes.
- Business name and tax ID should be listed on the invoice.
- The injured worker's name and the Pinnacol claim number should be listed on the invoice.
- The individual interpreter's National Provider Identifier (NPI) number must be listed on the invoice.

- The interpreter's certification should be listed.
- The name of the interpreter listed on the bill must match the name of the interpreter on the certificate Pinnacol has on file. This includes full name and any titles or suffixes.
- The interpretation language should be listed on the invoice.
- One interpreter and one injured worker should be listed per invoice.
- The name of the Pinnacol representative who authorized the service must be on the bill.
- Payment is based on billed units of 15-minute increments. The invoice should reflect the number of units and the total billed amount.

Scheduling

- An interpreter's location (in-person, video, or audio) should be provided based on the provider's availability and preference.
- For languages that certification is eligible, a certified interpreter should be assigned to an injured worker over a qualified interpreter.
- For languages certification is not eligible, a qualified interpreter will be assigned to an injured worker.

Medical Appointments

The interpreter should:

- Leave the room when a provider leaves the exam room during an appointment. The interpreter should confirm with the clinic its expectation of where the interpreter should wait.
- Not complete forms or write for injured workers. Written translation requires different formal training and specific skills.
- Bill for interpretation services when performed at a facility or ambulatory surgery center for both inpatient and outpatient procedures. Payment for interpretation services is included in the facility's reimbursement.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Vendor Participation Standards

All DMEPOS vendors should be licensed and in good standing with the Colorado Secretary of State (or equivalent licensing body in other states where services are provided) as required by the Colorado DOWC Rule 16. the Colorado DOWC Rule 16.

Communication with Pinnacol

The DMEPOS vendor should:

- Return calls and emails to Pinnacol within two business days.
- Respond to written correspondence from Pinnacol or its representative within ten business days.

Billing

- DMEPOS vendors must submit bills using nationally recognized HCPCS codes when applicable.
- For unspecified items or HCPCS codes without an established fee schedule, reimbursement will be based on the vendor's actual cost of the item, as evidenced by a supplier's invoice. For items requiring fabrication or customization, reimbursement will consider the vendor's cost of materials and the labor involved in the fabrication and customization.
 - Unaltered invoices are required. Altered, edited or handwritten invoices are unacceptable.
- Invoices must be dated within 24 months of the date the equipment was provided to the injured worker.
- The invoice item description must match the billed item.
- Shipping and handling costs are included in the reimbursement of the item and are not separately payable.

Referral Requirements

- DMEPOS vendors must only dispense equipment and supplies based on a detailed, written order from an authorized treating provider unless Pinnacol specifically states the detailed, written order is unnecessary.
- The order must include:
 - Injured worker's full name, Pinnacol Assurance claim number, and date of the order.
 - Printed name and signature of the prescribing provider.
 - Accurate HCPCS code(s), modifiers, and a clear description of the item(s), including accessories and features.
 - Diagnosis and documented medical necessity for the requested equipment.
 - Specified frequency and duration of use and whether the item is for rental or purchase.
- If the order is incomplete or unclear, the DMEPOS vendor must contact the prescribing provider to obtain the necessary information before fulfilling the order.

Equipment Maintenance and Repair

The DMEPOS vendor:

- Must provide high-quality, durable medical equipment and supplies that meet or exceed industry standards.
- Must offer equipment maintenance and repair services, either directly or through authorized service providers.
- Should provide a copy of the equipment warranty if covered by one.
- Must ensure delivery and proper setup of equipment, including clear instructions and education on its use and care to the injured worker.

Supplies

- Supplies included in the initial device setup cannot be billed separately in the first month.
- Replacement supplies may be billed when the injured worker or prescribing provider requests additional supplies.
- Monthly DMEPOS auto-shipping is prohibited.
- Documentation of the injured worker or prescribing provider's request for additional supplies must be sent with the bill.
- For long-term supplies, prior authorization from Pinnacol's claims management team is required.

Transportation Vendor Participation Standards

Transportation providers must be licensed through the Public Utilities Commission or other appropriate state registration agency. Proof of licensing must be provided to Pinnacol upon request.

Communication with Pinnacol

- Return calls and emails to Pinnacol within two business days.
- Respond to written correspondence from Pinnacol or its representative within ten business days.

Scheduling

The transportation vendor should:

- Provide transportation services to injured workers for claim-related medical services only.
- Allocate sufficient time to ensure the injured worker arrives at the drop-off location with adequate time for appointment check-in.
- Provide a pickup window confirmation to the injured worker.
- Immediately notify the injured worker and Pinnacol of any unexpected delays or changes to the scheduled transportation.
- Injured workers should not wait more than 15 minutes past the scheduled pickup time.
- Confirm with Pinnacol once transportation has been successfully provided.

Billing

- The business name and tax ID should be listed on the invoice.
- The injured worker's name and the Pinnacol claim number should be listed on the invoice.
- The name of the Pinnacol representative who authorized the service must be on the invoice.
- The invoice should include the addresses of the pick-up and drop-off locations.

- Only loaded mileage should be included in the invoice. Loaded mileage is defined as the distance a vehicle travels while carrying an injured worker from the pick-up location to the drop-off location.
- Transportation services not prior authorized by Pinnacol will not be reimbursed.
- Injured workers are responsible for any costs associated with separate agreements for non-medical transportation services.

Vehicle Safety and Maintenance

- The vehicle should be clean inside and out and be always maintained in a safe and serviceable condition.
- Transportation vendors should have adequate insurance coverage, as required by state law or regulation, to protect the vehicle, riders and operating personnel.

Driver Qualifications

- Transportation vendors should employ drivers with valid licenses and clean driving records, meaning the driver has no moving violations, at-fault accidents, major traffic violations such as DUIs or reckless driving violations, or point reductions. Pinnacol Assurance reserves the right to request and review documentation to verify compliance with these driver qualification requirements.
- Drivers must demonstrate professionalism and provide good customer service by adhering to confidentiality, assisting injured workers with mobility needs, and maintaining respectful communication.
- The driver's badge or name tag should be worn or displayed clearly and be distinctly visible to the injured worker.
- Transportation vendors must comply with Colorado law regarding the employment of legal workers, including verifying employee eligibility and ensuring subcontractors do the same. Vendors must notify Pinnacol of any known violations and cooperate with state investigations.

Accessibility

- Transportation vendors must only accept service requests they are equipped to handle based on their available services and vehicle types.
- The most economically available route should be driven from the pick-up location to the drop-off location.

Generic Participation Standards

This document outlines the participation standards for SelectNet providers and vendors not identified in the previous participation standards sections. These standards are in addition to any other agreements or contracts between the provider/vendor and Pinnacol Assurance.

General Expectations

All providers and vendors not identified in the previous participation standards sections are required to adhere to the "General Expectations" for Compliance, Communication, Scheduling &

Wait Times, Documentation, Prior Authorization and Confidentiality. These general standards form the foundation of our partnership and apply across all services provided to injured workers on.

Compliance

- Providers must follow all applicable laws, regulations, and Pinnacol policies and procedures.

Communication with Pinnacol

Providers must maintain open and timely communication with Pinnacol and other involved parties, such as the injured worker, their employer, and other healthcare providers.

- Return calls and emails to Pinnacol within two business days.
- Respond by fax, mail or email to written correspondence from Pinnacol or its representative within ten business days.

Scheduling and Wait Times

- Providers should generally offer services during standard weekday business hours. Rural/frontier providers must tailor availability to community needs.
- The wait time for scheduled appointments should not exceed 30 minutes.
- Evaluate/treat the injured worker within five business days of referral.

Documentation

Providers must maintain accurate and complete records of all services provided and submit required documentation to Pinnacol when requested.

- Provide comprehensive and legible medical documentation to Pinnacol and/or the referring provider within seven business days of the request.

Prior Authorization

Providers and vendors must adhere to the prior authorization guidelines set by the Colorado DOWC Rule 16 and/or by Pinnacol Assurance.

Confidentiality

Providers must maintain the confidentiality of injured workers' information.

Pinnacol's Right to Modify

Pinnacol reserves the right to modify these participation standards at any time.

Limitations on Enforcement

Pinnacol acknowledges that certain participation standards may not apply to all provider types or groups due to legal or regulatory constraints. In such cases, Pinnacol will not enforce the inapplicable standard.

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 – Claims Submission Instructions – CMS-1500

Field #	Field Description
1	Payer (Pinnacol = other) – not required
1A	Insured's ID number = Pinnacol's claim number
2	Patient name
3	Patient birth date
4	Insured name (employer)
5	Patient address
7	Insured address (employer address)
11	Insured policy or group number (or FECA for federal employees)
11B	Pinnacol claim number
14	Date of current illness or injury
21	Diagnosis code(s) in ICD10 format
23	Prior authorization number (or point of pick-up zip code for ambulances)
24A	Date(s) of service
24B	Place of service
24D	Procedures, services or supplies (CPT/HCPCS and modifiers)
24F	Chargers (for all units billed on 24D service)
24G	Days or units (anesthesia minutes, # tablets, package size, # days, # units/ procedure code)
24J	Rendering provider ID (NPI) – leave blank if no NPI
25	Federal tax ID number (SSB or EIN) – no dashes
28	Total charge – the total of all line-item charges
31	Signature or printed name and credentials of actual provider and date
32	Service facility name, address and zip code where service is rendered
32A	NPI of the service facility
33	Billing provider name, address zip and phone – payable or correspondence address
33A	NPI of billing provider

- Diagnosis codes identify the nature of an illness or injury by examining the symptoms. If you do not perform a diagnosis, obtain the diagnosis from the authorized treating physician.
- For payments, please fax your completed W9 IRS tax form to Pinnacol's provider relations specialists at 303.361.5945. The form is available at <https://www.irs.gov/forms-pubs/about-form-w-9>
- Payment may be delayed if your handwritten CMS-1500 is not legible.
- If there is missing information on the CMS-1500, it may cause a delay or denial of services.

Appendix D – Process Used to Address 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 and contract termination. This guideline does not apply when neither quality of care or quality of service issues are involved, and disaffiliation or contract termination occurs as a result of:

- The lack of need for providers in a discipline.
- The non-renewal of a contract for neither a quality of care nor quality of service issue
- A provider ending association with the contracted group.
- A provider or contracted group ceasing its operation
- Contract disputes.
- Termination of the SelectNet Agreement pursuant to disaffiliation without cause provisions.

These guidelines apply only to network providers who do not meet network standards or requirements for quality of care or quality of service.

The Provider Network Management department 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. 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.

With respect to quality of care concerns, the NAC will investigate and decide whether to take or recommend a particular action. A provider is entitled to written notice of recommended adverse actions as referenced in subparagraph 1.) D.) 4of the Quality of Care Concerns procedures below, and may request a hearing regarding such actions. The hearing will be held by an impartial hearing officer. Following the hearing and after the NAC reviews the hearing officer's report, the NAC will affirm, modify, or reverse its prior recommendation. The CQSC shall adopt the recommendation of the NAC. The findings and recommendations of the hearing officer and of the CQSC will be forwarded to Pinnacol's Executive Committee (AVP of Medical Operations, AVP of Claims, and AVP Deputy General Counsel). The provider may appeal to the Executive Committee regarding CQSC's decision regarding recommended adverse action. The Executive Committee has final authority related to taking adverse actions for quality of care concerns.

Regarding quality of service concerns, CQSC will investigate and decide whether to take particular action. A provider is entitled to written notice of a planned corrective or other disciplinary action, and may request an informal meeting with the CQSC, or subcommittee thereof. The CQSC has the final authority to act regarding the quality of service concerns it investigates.

Procedure

I. Quality of Care Concerns

A. Issues that qualify as Quality of Care concerns

Issues relating to quality of care are those involving the competence or professional conduct of a provider (which conduct affects or could adversely affect the health or welfare of a patient or patients). 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 deliver or order services at an appropriate point or level of care issues relating to quality of care may be identified from provider feedback loops as explained below or may be identified from any other source (e.g. claims representative, medical case manager, injured worker) that brings the issues to Pinnacol's attention.

Any SelectNet provider with five or more valid provider feedback loop entries, representing substantiated quality of care issues during the current credentialing cycle, must be reviewed by the NAC. A valid provider feedback loop entry occurs when a quality of care standard has not been met and is reported to, investigated, and documented by Pinnacol's Provider Network Management department. Quality of care requirements are outlined in the provider's SelectNet Agreement, the SelectNet Provider Manual, the SelectNet participation standards and the SelectNet credentialing standards.

In addition, the NAC may, in its discretion, review a provider who has fewer than five provider feedback loop entries during the current credentialing cycle or when serious quality of care concerns are identified from other sources.

In all cases, when substantiated provider feedback loops or other quality of care issues are determined to have occurred, the SelectNet provider shall receive written notification from Pinnacol noting (1) the issue(s) in question and the performance standard(s) that were not met; (2) information related to how the particular issue was resolved; (3) the number of substantiated issues the provider has accumulated since their last credentialing cycle; and (4) the criteria that will eventually (or immediately) result in a mandatory NAC review.

B. Initial review

Regardless of whether the information comes from provider feedback loops or some other source, when a question has been raised regarding the provider's clinical

competence or professional conduct or whether the provider is meeting network quality standards, the matter may be referred to the Provider Network Management department and the Senior Medical Director.

The person to whom the matter is referred shall conduct or arrange for an inquiry to determine whether the question raised has sufficient credibility to warrant investigation. The initial review may include a request for a written response from the provider. If investigation is warranted, the matter will be forwarded in writing to the CQSC. Action taken pursuant to the Paragraph does not constitute an investigation.

C. Investigation

1. Initiation of investigation: When a question regarding a provider's clinical competence or professional conduct or regarding whether the provider is meeting network quality of care standards has been referred to the CQSC, the CQSC will assign the matter to the NAC, which shall review the matter and determine whether to conduct an investigation, direct the matter to be handled pursuant to another policy, or process in another manner.
2. Conduct of investigation: Upon determination to investigate, the NAC may in the course of the investigation and in its reasonable discretion:
 - Meet informally with the provider
 - Collect relevant documentation
 - Discuss issues with other people who have knowledge of the facts or conduct in question (Providers authorize the release of such information by virtue of their SelectNet Agreement.)
 - Obtain independent review (e.g., from a physician advisor or other peer provider)
 - Request a written response from the provider, after notice to the provider of the nature of the issues under investigation and the deadline to respond
 - Analyze information to determine if further action is warranted
 - Take any steps consistent with the need to reasonably investigate the issue

The NAC may initiate an investigation without prior notice to the provider. The NAC may conduct the investigation itself and/or may engage an external peer review consultant to carry out the investigation and/or assist the NAC.

D. Determination

1. The decision whether to take or recommend a particular action, including disaffiliation, will be made by majority vote of the NAC.
2. As soon as practical after the conclusion of the investigation, the NAC shall take action that may include, without limitation:

- Determining that no further action should be taken and the matter be closed
 - Deferring action if the NAC believes more information is needed
 - Issuing letters of concern; this does not prevent Pinnacle from issuing informal written or oral warnings outside the mechanisms in this guideline
 - Referring to the Center for Personalized Education for Professionals (CPEP) for coursework or practice monitoring
 - Referring to the Colorado Physician Health Program (CPHP) for medical or mental health examination to determine 'fitness' to exercise affiliation rights safely
 - Recommending denial of participation or denial of renewal application
 - Recommending disaffiliation, contract termination, or both, solely of the subject provider
 - Recommending disaffiliation, contract termination, or both, of the subject provider and any affiliated group
 - Recommending conditional continued affiliation
 - Taking all other actions deemed appropriate under the circumstances including the issuance of a complaint to the Colorado Medical Board or other relevant authority
3. For actions other than recommendations for adverse action, the NAC action is final and effective immediately, and the NAC will report its action to the CQSC. For recommendations for adverse action, after completion of the procedures outlined in I.B through I.D, CQSC shall adopt the final recommendation of the NAC regarding quality of care concerns and forward the final recommendation to the Executive Committee as provided in this guideline.
 4. An adverse action is defined as an action taken based on the competence or professional conduct of a provider that adversely affects or could adversely affect the health or welfare of a patient, and that adversely affects the provider's affiliation. For example, adverse action includes denial of participation, denial of renewal application, suspension of membership within the network, disaffiliation and contract termination.
 5. Except as otherwise provided in I.D, if the NAC recommends an adverse action, the Director of Provider Network Management, Senior Medical Director, or their designee, will send notice to the provider, to include the following:
 - The NAC is recommending adverse action be taken
 - A description of the recommended action
 - The reason(s) for the recommended action
 6. Within thirty (30) days after the date of the letter, the provider may submit a written request for a hearing.

7. The hearing shall be held before a hearing officer selected in accordance with I.H.
8. The right to a hearing may be forfeited if the provider fails, without good cause, to appear at the hearing.
9. The provider has the following rights at the hearing: (1) to representation by an attorney or other person of the provider's choice, (2) to have a record made of the proceedings, copies of which may be obtained by the provider upon payment of any reasonable charges associated with the preparation thereof, (3) to call, question and cross-examine witnesses, (4) to present evidence determined to be relevant by the hearing officer regardless of its admissibility in a court of law, and (5) to submit a written statement at the close of the hearing. The provider has no right to a hearing if the reason for the proposed action is suspension or revocation of the provider's license or inability to obtain malpractice insurance.
10. The provider has the following rights upon completion of the hearing: (1) to receive the written recommendation of the hearing officer, including a statement of the basis for the recommendations, and (2) to receive a written decision from the NAC, including a statement of the basis for the decision.

E. Emergency Suspension

1. An emergency suspension from the network may be imposed if a provider's care may result in imminent danger to the health of any individual.
2. If the NAC, or the Senior Medical Director and the Director of Provider Network Management, determine in good faith from the information available that there is an imminent danger or jeopardy to workers, then the NAC, or the Senior Medical Director and the Director of Provider Network Management or designee, may impose an emergency suspension prior to the standard investigation process required under B above.
3. The Senior Medical Director will notify the provider by telephone of the determination. The Senior Medical Director will follow up in writing by certified mail, notifying the provider of the emergency suspension of participation in SelectNet. The letter will inform the provider that the NAC will, within 10 days of the date of the emergency suspension, evaluate and recommend to the CQSC whether to continue the suspension during the investigation and decision-making process and that the CQSC will adopt the recommendation within 14 days of the date of the emergency suspension.
4. The Senior Medical Director, the Director of Provider Network Management and the AVP of Medical Operations will investigate and make a recommendation to the CQSC within ten (10) days, and the CQSC will adopt the recommendation within fourteen (14) days, as to whether to continue the suspension during the investigation and decision-making process. The Director of Provider Network Management, or designee, will notify the leadership of Insurance Operations regarding the emergency suspension.
5. The NAC will investigate and report its findings and recommendations to the CQSC within ten (10) days as to whether the suspension should be modified, continued, or terminated pending completion of the investigative and decision-making process in this guideline. The NAC shall also determine that more investigation is

warranted pursuant to I.C or act pursuant to I.D, and the matter will proceed according to this guideline.

6. The CQSC will adopt the NAC's recommendation regarding continued suspension no later than fourteen (14) days after the imposition of the emergency suspension. If the NAC recommends that the quality of care concern can be handled in the standard process, the CQSC will lift the suspension, and the Director of Provider Network Management or designee will inform the provider in writing of its decision. If the NAC recommends that the suspension is warranted, the CQSC will continue the suspension, and the Director of Provider Network Management or designee will inform the provider in writing of its decision as soon as possible or within five (5) days of the decision.
7. If a provider is suspended for more than fourteen (14) days pursuant to this Section I.D, or if the NAC makes a recommendation for adverse action, notice to the provider shall be given pursuant to I.D.4 above, and the provider will be entitled to the process set forth in this guideline.

F. Prehearing Procedures

1. If the provider submits, within thirty (30) days after the date of the notice letter, a written request to the NAC for a hearing, the Director of Provider Network Management Director or designee will provide the NAC and the provider with 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 may be any other impartial attorney, provided that all candidates must 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 (5) 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 will bear the costs of the hearing officer.
2. The parties and the hearing officer will schedule the hearing for a date not less than thirty (30) days nor more than sixty (60) days after the NAC's receipt of the request for hearing unless the parties mutually agree to a date outside this time frame.
3. The Director of Provider Network Management or designee will send written notice of the date, time and place of the hearing to the provider and the hearing officer. The notice will also: (a) list any witnesses that the NAC intends to call, and (b) furnish documents expected to be introduced.
4. 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.
5. The provider will furnish to the NAC 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, no later than ten (10) days before the scheduled hearing.

The NAC will give the provider and the hearing officer a list of the documents it intends to introduce at the hearing no later than ten (10) days before the scheduled hearing. Each party will bear its own attorney fees and hearing costs.

6. If an issue arises as to whether a party is allowing access to documents as provided in F.4above, the party requesting the access may ask the hearing officer to consider and rule on the request, taking into account: (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.

G. Hearing Procedures

1. The hearing officer will record the hearing with 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 and question the other party as a witness. However, the hearing officer may establish reasonable time limits on the presentation of each party's case.
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 upon which responsible people are accustomed to relying in the conduct of serious affairs. The hearing officer may ask questions of the parties and witnesses.
4. Generally, the burden of proof will be on the NAC to show, by the preponderance of the evidence, that its decisions are supported by the facts. In the case of emergency suspension of practice rights in the network, the burden is on the NAC to demonstrate that an emergency suspension was necessary and that the issue(s) involved could not have been investigated in the normal course.
5. At the close of the hearing, the provider may submit a written statement to the hearing officer and must provide the NAC with a copy of any such statement.
6. Within fourteen (14) days after the hearing, the hearing officer will submit a written report containing the officer's findings and recommendations based on those findings to the NAC. The hearing officer may recommend upholding the NAC recommendation, reverse it, or modify it. The Director of Provider Network Management or designee will send a copy to the provider.
7. Within twenty-eight (28) days after receipt of the hearing officer's report, the NAC shall consider the report and affirm, modify or reverse its prior recommendation, decision, or proposed decision. The NAC shall indicate its action in writing with a statement of the basis for its decision. The NAC shall submit a copy of its written recommendation together with the hearing officer report and all other relevant documentation to the CQSC, which shall in turn adopt the NAC's recommendation. The Director of Provider Network Management or designee or Senior Medical Director shall send CQSC's adopted recommendation and documentation to the provider and to the Executive Committee.

8. If the CQSC recommends adverse action against the provider, the Director of Provider Network Management or designee or Senior Medical Director shall give the provider notice of the right to request an appellate review by the Executive Committee, and that the provider must make such a request within fourteen (14) days of the date of the notice.

H. No Hearing Request

If the NAC does not receive a timely written request for a hearing, or if the provider waives the right to the hearing by a signed statement of waiver, the provider is deemed to have waived the right to hearing and appellate review and to have accepted the recommended action. The CQSC shall adopt the recommendation.

I. Appeal

1. If the provider does not timely request appellate review, the provider waives the right to appeal and is deemed to have accepted the recommended action.
2. Within fourteen (14) days of the date of notice of the right to appeal a recommendation of adverse action, the provider may file a written appeal with a brief statement of the basis for appeal. The request must be received by the Director of Provider Network Management or designee or Senior Medical Director electronically with confirmed receipt or by certified or registered mail on or before the deadline to request appeal.
3. Upon receipt of a written appeal, the Executive Committee will review the findings and recommendations of the hearing officer and the recommendation of the CQSC and any documents that support each determination. Members of the Executive Committee should not have participated in any investigation or deliberations leading to the recommendation for adverse action under consideration.
4. The grounds for appellate review are limited to claims of (a) substantial failure to comply with pre-hearing procedures so as to deny basic fairness or reasonable due process; (b) recommendation made by the CQSC or the hearing officer that was arbitrary or capricious; or (c) the recommendation of the CQSC was not supported by evidence in the hearing record. Arguments and evidence not presented at hearing will not be considered on appeal absent good cause for the failure to present them at hearing.
5. Pursuant to deadlines set by the Executive Committee, each party may submit a written statement in support of its position on appeal and shall provide the opposing party with a copy of any submitted written statement.
6. The Executive Committee may, if it deems necessary, request further supporting materials from the CQSC or the provider.
7. The Executive Committee may, in its sole discretion, schedule an oral argument and allow each party or its representative to make a time-limited oral argument on the record of fifteen (15) minutes or more.
8. After deliberation, the Executive Committee, upon majority vote, may adopt, modify or reverse the CQSC action that is the subject of the appeal, or refer the matter back to the CQSC for further review and recommendation.

The Executive Committee should complete its review process within sixty (60) days from the date of the written appeal. If the matter is referred back to the CQSC for further review and recommendation, the CQSC shall refer the matter to the NAC, which shall promptly conduct its review and make its recommendations to the CQSC who will in turn adopt and make those recommendations to the Executive Committee, in accordance with the instructions given to it by the Executive Committee. This further review process shall not exceed sixty (60) days in duration, except as the parties may otherwise stipulate.

9. The final decision of the Executive Committee shall constitute final action that takes effect immediately and is not subject to further review. The Executive Committee will forward its final decision to the CQSC. The Director of Provider Network Management or designee or Senior Medical Director will send written notice of the final decision to the provider.

J. Final Action of the Executive Committee

1. Except in the event of an appeal pursuant to I.I, after receipt of a recommendation from the CQSC made in accordance with this guideline, the Executive Committee shall either adopt or reject the CQSC's recommendation, in whole or in part, or refer the matter back to the CQSC, who shall refer the matter back to the NAC for further reconsideration. Any such referral shall include a statement of the reasons therefore and set a time limit within which a subsequent recommendation to the Executive Committee must be made. After receiving any such subsequent recommendation, the Executive Committee shall make its decision.
2. The Executive Committee's final decision shall constitute final action that takes effect immediately and is not subject to further review. The provider will be sent a notice of each action taken.
3. If the final action denies a provider's application for affiliation or renewal or results in disaffiliation and contract termination, the provider may not apply for affiliation with Pinnacol for a period of four (4) years following the final decision, unless the final decision states otherwise.
4. If the final action is suspension or termination of the provider's affiliation and contract, the Director of Provider Network Management or designee or Senior Medical Director will direct the Credentialing Coordinator to restrict or remove the provider from the credentialing process (see operating guidelines for Credentialing) and network provider database, as appropriate.

K. Standard for Professional Review

All participants in the professional review process will make recommendations or take actions in good faith in the reasonable belief that (a) 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 are afforded to the provider or after such other procedures as are fair to the provider under the circumstances; 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.

L. 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.

M. Reporting

1. 1. Pinnacol is required by law to report certain adverse actions to federal and state authorities. For example, for physicians and dentists, Pinnacol is required to and will submit a report in accordance with federal laws and regulations to the National Practitioner Data Bank (NPDB) and the appropriate state licensing board under the following circumstances:
 - Actions taken based on the competence or professional conduct of a physician or dentist that adversely affects or could adversely affect the health or welfare of a patient, and that adversely affects the physician or dentist's affiliation with Pinnacol for more than 30 days. This includes suspension of a provider's affiliation for more than 30 days pursuant to subparagraph I.) E of the Quality of Care Concerns procedures above, as well as disaffiliation.
 - If the physician or dentist voluntarily disaffiliates and terminates his or her contract with Pinnacol, or withdraws their application during the initial credentialing process, while under an investigation pursuant to this guideline and before the investigation is completed.
 - If the physician or dentist voluntarily disaffiliates and terminates his or her contract with Pinnacol in return for not investigating.
2. Reports will include information required by law, such as the name of the provider, a description of the acts or omissions or other reasons for the action or, if known, for the voluntary disaffiliation, and other information required by federal law and regulation.
3. Pinnacol will attempt to notify the provider in advance of any report made.
4. For licensed health care practitioners other than physicians and dentists, Pinnacol is authorized to and may submit a report under the same circumstances outlined in M.1 above.
5. There may be other instances in which Pinnacol is required or permitted to report adverse actions. There may be other instances in which Pinnacol or individuals associated with Pinnacol are permitted to report concerns about physician conduct to federal or state authorities, and this network guideline is not intended to impact or impair the ability to make such reports.

II. Quality of Service Issues

A. Issues that qualify as Quality of Service

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 SelectNet Agreement (e.g., breach of the agreement) or the SelectNet Provider Manual or DOWC Rules 16 and 18
- 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 Assurance contractual administrative performance expectations
- Failure to meet Pinnacol Assurance scheduling and wait time expectations
- Failure to timely verify, upon request, an injured worker’s inability to work
- Communications that are false or maliciously critical of Pinnacol and are calculated to injure Pinnacol

Note: The process in this Section II applies to a group practice or ancillary service vendor, if the practice or vendor 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, vendor or individual as applicable.

Provider feedback loops for individual participants in a group practice are tracked during a three-year credentialing cycle. Feedback for a group practice or ancillary service vendor is tracked during a rolling 24-month period.

Participants in group practices are allowed up to five valid feedback loops, either of varying or similar concerns, during their current credentialing cycle, before they are reviewed by the CQSC.

A group practice or ancillary service vendor are allowed a specific number of valid feedback loops during a rolling 24-month period, either of varying or similar concerns, based upon the practice or vendor’s bill count, before there will be a review by the CQSC. The bill count and the number of valid provider feedback loops are listed below:

Bill Count	FBL Count
≤ 3,000	5
3,001-4,000	6
4,001-5,000	7
5,001-6,000	8
6,001-7000	9
≥ 7,001	10

A valid provider feedback loop entry occurs when a quality of service standard has not been met and is reported to and documented by Pinnacol's Provider Network Management department. 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 department. Quality of service requirements are outlined in the provider's SelectNet Agreement and the SelectNet Provider Manual.

In addition, the CQSC may, in extraordinary circumstances based upon the severity of any provider feedback loop entries which total any number less than five during the current credentialing cycle or rolling 24-month period, consider a provider for review and further action if warranted.

In all cases, when a substantiated provider feedback loop issue is determined to have occurred, the SelectNet provider shall receive written notification from Pinnacol noting (1) the issue in question and the performance standard or DOWC rule that was not met; (2) information related to how the particular issue was resolved; (3) the number of substantiated issues the provider has accumulated during the current credentialing cycle or rolling 24-month period and the total number of issues permitted before a mandatory committee review ensues. The provider may submit a statement for entry into the tracking system reflecting the provider's position on the issue or its resolution.

B. Investigation

1. An investigation will be conducted when the Provider Network Management department is informed of a potential quality of service concern. The Provider Network Management department 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 people who have knowledge of the facts or conduct in question (Providers authorize the release of such information by virtue of their SelectNet Agreement)
 - Obtain independent review (e.g., from a physician advisor or other peer provider)
 - Analyze information to determine if further action is warranted
 - Take any other steps consistent with the need to reasonably investigate the issue

C. 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 SelectNet Agreement). The decision whether to take particular action will be made by majority vote of the CQSC.
3. 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
 - 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
 - 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 of the CQSC.
7. If the CQSC determines that corrective action, or disciplinary actions including disaffiliation will be imposed, the Director of Provider Network Management or designee will notify the provider of the action taken and of the quality of service concern that prompted the action. This letter will also inform the provider of the right to request, within fifteen (15) days, an informal meeting with CQSC to discuss reconsideration of the action.

D. Informal Meeting

1. If the provider submits a timely written request for an informal meeting for reconsideration, the CQSC itself will hold, or assign a subcommittee to hold, the meeting within fifteen (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 or designee will send, no later than ten (10) days before the meeting, written notice of the time, date, duration and place for the meeting to the provider.
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 thirty (30) days after the meeting. The CQSC will, within ten (10) days after receipt of the recommendations, determine whether to affirm, modify or rescind its action. The Director of Provider Network Management or designee 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 this Section II.

E. Provider Improvement Plan

1. A provider improvement plan (PIP) may be initiated when a provider has reached a valid provider feedback loop (FBL) count that puts the provider three (3) or less away from its allowed threshold for FBLs or if the Provider Network Management team discovers a trend in feedback
2. The purpose of the PIP is for the Provider Network Management team and provider to collectively problem solve and develop processes that will address negative FBLs regarding the provider's quality of service. The goal of the PIP is to help the provider avoid a potential formal review by CQSC.
3. Each PIP will be in effect for 90 days with check-ins from the Provider Network Management team to assess the provider's progress.
4. If the provider receives one or more reported negative FBLs during the 90-day period, the provider may be subject to review by CQSC to determine if the provider will continue as a participant in the SelectNet network.
5. At the end of the 90-day period, if the group practice has successfully completed the PIP, the PIP will terminate.
6. Although the provider is not required to complete the PIP, the provider is encouraged to work through the process to help prevent future FBLs and a possible formal review by the CQSC.



Glossary

Section 8

Glossary of Terms	
AMA Guides	American Medical Association Guides to the Evaluation of Permanent Impairment - The reference guide (Third Edition, Revised) which must be used in the Colorado workers' compensation system to determine an injured worker's permanent impairment rating.
ATP	Authorized treating provider - The designated provider who has primary responsibility for managing an injured worker's medical care; any other healthcare provider who assists in providing care to an injured worker; any other healthcare provider the DOWC categorizes as an ATP (see DOWC Rule 16-2).
CAQH	Council for Affordable Quality Healthcare - Pinnacol's credentialing verification organization.
Claims management team	Claims management team – A multidisciplinary team within Pinnacol responsible for the administration and processing of workers' compensation claims. The team typically includes claims representatives and medical case managers.
CMS-1500	Centers for Medicare & Medicaid Services 1500 - The standard bill form used by a non-institutional provider or supplier.
CQSC	Credentialing and Quality of Service Committee - A multi-disciplinary committee within Pinnacol responsible for decisions related to network affiliation, credentialing, corrective actions, and provider disaffiliation. CQSC's primary purpose is to ensure compliance with Pinnacol's network policies and procedures while maintaining quality within the provider network.
CVO	Credentialing verification organization - An organization used by Pinnacol to verify licensed medical practitioners' qualifications to enroll the practitioner into Pinnacol's preferred provider network, SelectNet.
DIME	Division Independent Medical Examination - A State of Colorado Division of Workers' Compensation-sponsored independent evaluation of medical issues related to MMI and impairment in a workers' compensation case.
DMEPOS	Durable medical equipment or durable medical equipment, prosthetics, orthotics, and supplies - Medical equipment or supplies ordered by a medical professional used in the home to aid in an injured worker's recovery, to improve the injured worker's quality of life, or to assist in activities of daily living.

Glossary of Terms

DOWC	Division of Workers' Compensation – A division of the Colorado Department of Labor that oversees the administration and operation of the workers' compensation system in Colorado. The DOWC establishes and enforces the rules and guidelines to which all parties in a workers' compensation claim must adhere.
EOB	Explanation of benefits - A document sent by Pinnacol to providers or vendors who have billed for services for treating an injured worker. The document explains what services were paid, what services were denied, and the total payment amount. This term is used interchangeably with EOR.
EOR	Explanation of remittance - A document sent by Pinnacol to providers or vendors who have billed for services for treating an injured worker. The document explains what services were paid, what services were denied, and the total payment amount. This term is used interchangeably with EOB.
FBL	Provider feedback loop - Positive or negative feedback reported to Pinnacol's Provider Network Management department regarding a provider or group practice.
IR	Impairment rating - A permanent impairment rating determined by a Level II board-certified physician after MMI has been reached. The rating may include a percentage of the body part(s) affected, which may be converted into a whole-person impairment rating.
MMI	Maximum medical improvement - The point in time when any medically determinable physical or mental impairment as a result of the injury has become stable and when no further treatment is reasonably expected to improve the condition.
MTG	Medical Treatment Guidelines - Evidence-based treatment guidelines developed by the DOWC to promote the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost.
NAC	Network Affiliation Committee - A subcommittee of the CQSC within Pinnacol, focusing primarily on quality of care issues and reviewing adverse licensure information of providers.
Non-Division IME aka IME or RIME	Non-Division Independent Medical Examination - An independent medical evaluation performed by a medical professional on an injured worker who was not previously involved in the treatment of the injured worker to evaluate the injured worker's course of prior treatment and current condition. This type of IME may also be referred to as a respondent independent medical examination (RIME).

Glossary of Terms	
NP	Nurse practitioner - A type of non-physician advanced practice clinician.
OTC	Over the counter - Medication sold directly to an injured worker without the requirement of a prescription.
PA	Physician assistant - A type of non-physician advanced practice clinician.
PBM	Pharmacy benefit manager - A third-party administrator of a prescription drug program that is responsible for processing and paying drug bills.
PCP	Primary care provider - The occupational health primary care provider who is the designated provider for an injured worker and is responsible for determining causality, restrictions, MMI, and impairment.
PIP	Provider improvement plan - A structured process initiated by Pinnacol's Provider Network Management team to address and rectify a provider's performance issues, specifically related to negative feedback loop (FBL) counts. It is a collaborative effort between the team and the provider to correct the identified issues and prevent future occurrences, with the goal of helping the provider avoid a formal review by CQSC.
PRS	Provider relations specialist - A Pinnacol staff member who is the primary contact for providers to utilize for questions or issues related to SelectNet, DOWC rules or guidelines, or Pinnacol's participation standards.
RTW	Return to work - A department within Pinnacol whose primary focus is to help injured workers back to work as soon as medically possible. This department's staff directly work with employers, providers, injured workers, and claims management staff. An acronym used for the return-to-work process. The process focuses on restoring an injured worker to their former work abilities.
The Act	Workers' Compensation Act of Colorado - The Act is part of the Colorado Revised Statutes and was adopted by the Colorado General Assembly to ensure quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of litigation.
UB-04	Unified billing form 04 - The billing form for institutional facilities such as hospitals or outpatient facilities.