



GEORGIA STATE BOARD OF WORKERS' COMPENSATION

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BEST PRACTICES GUIDELINES FOR MEDICAL PROVIDERS

July, 2007

THE PATIENT-PHYSICIAN ENCOUNTER

History

A thorough history should be taken including: symptoms, duration, nature, aggravating activities, and date of injury.

Work Status

Obtain information regarding work status including: type of work, how long on the job and any recent change. Communicate with employer as needed regarding patient's current job requirements.

Past Medical History

Inquire about prior problems, medical problems and medication allergies.

Treatment

Prior treatment modalities, surgery, therapy, including "alternative" methods, should be determined.

Social

Obtain information about hobbies, household and recreational activities, family history, litigation and psychosocial factors.

Prior Records

Obtain and review prior records as relevant. Do not rely on verbal reports.

Examination

A thorough physical examination of the area of symptoms should be performed including any reasonable and necessary testing. Note any loss of mobility, swelling or deformity.

Testing

Prior test results should be reviewed to avoid repeating diagnostic tests unnecessarily.

Diagnosis

A specific diagnosis should be made if possible, but if the diagnosis is not clear, there are ICD-9 codes available for pain, swelling, etc. This is preferable to labeling nonspecific musculoskeletal symptoms as tendonitis, etc. Terms such as "cumulative trauma" imply causality and should be avoided. The relationship, or lack thereof, of the complaint to the patient's job should be made as clear as possible. In Georgia, aggravation of a pre-existing condition is compensable as long as the aggravation lasts.

It is important to be as objective as possible and to assess each situation individually and impartially.

TREATMENT RECOMMENDATIONS

The plan should be spelled out in as much detail as possible, including the need for diagnostic testing, medications, therapy, surgery, activity modification, splinting, etc. Information about length of treatment, recovery and prognosis is very helpful to all parties. Return-to-work status should be specifically addressed. Describe activities to be avoided. Avoid vague references to "light duty." It is wise to contact the employer or insurer to determine if modifications are available rather than relying completely on verbal reports from the patient. Prescriptions should indicate in writing that it is a workers' compensation claim.

Documentation

The above information should be readable and available to all involved parties in a timely manner. Copies of the office notes should be made available to the employer/insurer/self-insurer. Also, document any phone calls regarding the patient, and keep copies of all correspondence. Referrals to other providers should be controlled by the "authorized treating physician" (ATP). The ATP may be determined in several ways.

1. Selected from a posted "Panel of Physicians" listing at least six physicians.
2. Selected from a list of at least ten physicians known as the "Conformed Panel of Physicians."
3. Member of a workers' compensation certified "Managed Care Organization" (MCO) contracted by employer.
4. The law also provides for either party to request an order from the Board designating and appointing an ATP.

COMMUNICATION

The law in Georgia specifies that the medical record in a workers' compensation claim, or when the employer has paid any medical expenses, is open to all parties to the claim. These records may include communications with psychiatrists or psychologists related to that workers' compensation claim. Parties to the claim consist of other providers, insurers, self-insurers, their attorneys and the patient. The medical records are available from the insurer/self-insurer at no cost to the parties; however, if the insurer fails to provide the injured worker or employer with copies, the provider may charge the insurer/self-insurer \$0.20 (twenty cents) per page, with a minimum charge of \$25.00 (twenty-five dollars), plus postage and tax if applicable.

Communication can be greatly facilitated by the provider's willingness to write or call the insurer/self-insurer, employer or case manager (when authorized) to resolve problems such as return-to-work issues, delayed recovery, etc. They are entitled to this information, and a provider who is willing to become involved in the communication process can greatly expedite resolution of problem cases. In some cases, a call from the doctor may be the first knowledge the employer/insurer/self-insurer has that the injury has occurred.

PAYMENT ISSUES

It is very important to verify coverage at or before the patient's initial visit, if possible. It is the responsibility of the provider's office to obtain this verification. This should be in writing via the patient or faxed to the provider's office. The law makes exceptions in emergency or urgent situations.

The workers' compensation law requires the employer/insurer/self-insurer to cover all reasonable and necessary treatment, items and services prescribed by the ATP.

Provider invoices/forms should be filed within a reasonable period from the date of services, using the CPT coding guidelines and proper ICD-9 diagnosis codes. Documentation of the service provided (office notes, operative notes, etc) is a requirement under Rule 205, and this greatly enhances payment processing. No physician, hospital or medical supplier shall bill the employee for authorized medical treatment.

Fees of physicians and charges of hospitals and other services under workers' compensation law shall be subject to the approval of the State Board of Workers' Compensation. No physician, hospital or other provider of services shall be entitled to collect any fees unless reports required by the Board have been made.

Reimbursement of services is done according to the Fee Schedule for Physicians, Surgeons, Pharmaceutical, Home Health Care, and Hospitals and Ambulatory Surgery Centers for services rendered under the Georgia Workers' Compensation Law. Reimbursement to the provider must be made within 30 days from the date the bill was received by the payer, according to state law. If not paid within 30 days, O.C.G.A. §34-9-203 imposes penalties accordingly. Any appeals must be made within 120 days from receipt of payment and/or explanation of benefits (EOB) (see O.C.G.A. §34-9-203). All bills must be submitted by the medical provider within one year of the date of service (see O.C.G.A. §34-9-203)

RESOLUTION OF DIFFICULT CASES

Roles of the Independent Medical Examination

In Georgia, an injured worker, after an accepted compensable injury and within 120 days of receipt of any income benefits, shall have the right to one examination at a reasonable time and place within this state or within 50 miles of the employee's residence, by a duly-qualified physician or surgeon designated by the employee and to be paid for by the employer/insurer/self-insurer. This Independent Medical Examination (IME) shall not repeat any diagnostic procedures which have been performed since the date of the employee's injury, unless the costs of such diagnostic procedures which are in excess of \$250.00 are paid by a party other than the employer/insurer/self-insurer.

The employer/insurer/self-insurer also has the right to ask the employee to submit to examination by a physician designated by the employer. Records of previous treatment should be reviewed and a thorough history and examination performed and documented, along with a summary of the assessment and recommendations. This evaluation does not create a physician/patient relationship and is separate from treatment.

Impairment vs. Disability

At the point of medical stability after treatment of a work-related injury, also known as Maximum Medical Improvement (MMI), the patient should be evaluated for any Permanent Partial Impairment (PPI) due to that injury.

"Impairment" is a medical term and in Georgia, is measured by the objective criteria outlined in the AMA Guide to the Evaluation of Permanent Impairment, 5th Edition. The impairment rating is expressed as a percentage of the involved area. "Disability" is a legal term and may include more subjective factors such as the type of work the patient does. Disability determinations are not done as a part of standard medical evaluation.