



FAQ's For Medical Providers

The Department of Labor and Industry (DLI) has prepared these FAQs to provide you general information on the changes to the Workers' Compensation Act for claims effective July 1, 2011, and after, though some information may apply to claims before that date as well.

This document is not all-inclusive, and responses may vary depending on the circumstances of a workers' compensation claim. Please contact DLI if you have any questions on applicability of the information.

For information related to medical service rules, fee schedules, and U & T Guidelines, you may contact Celeste Ackerman at celeste.ackerman@mt.gov or 406-444-6543.

General Questions

Q: How do I access the Montana Workers' Compensation U & T Guidelines?

A: The Guidelines are available on-line at: <http://mtguidelines.mt.gov/>

Q: How do I access the Montana Workers' Compensation Professional Fee Schedule and Facility Fee Schedule?

A: The fee schedules, set by DLI, are available [here](#).

Q: How do I access current travel, lodging and meals reimbursement?

A: The information is available [here](#).

Q: How do I access current Domiciliary Care Reimbursement?

A: The information is available [here](#).

Designated Treating Physician and Responsibilities

Q: What is the difference between a health care provider, a treating physician, and a designated treating physician?

A: A health care provider is a person authorized by the laws of Montana to provide health care within the authorized scope of practice.

Q: What is a treating physician (for claims on or after July 1, 2011)?

A: (39-71-116 (41), MCA) means the person who, subject to the requirements of 39-71-1101, is primarily responsible for delivery and coordination of the workers' medical services for the treatment

of a worker's compensable injury or occupational disease and is: 1) a physician licensed by the state of Montana under Title 37, chapter 3, and has admitting privileges to practice in one or more hospitals, if any, in the area where the physician is located; 2) a chiropractor licensed by the state of Montana under Title 37, chapter 12; 3) a physician assistant licensed by the state of Montana under Title 37, chapter 20, if there is not a treating physician, as provided for in subsection (37)(a), in the area where the physician assistant is located; 4) an osteopath licensed by the state of Montana under Title 37, chapter 3; 5) a dentist licensed by the state of Montana under Title 37, chapter 4; For a claimant residing out of state or upon approval of the insurer, a treating physician defined in subsections (41)(a) through (41)(e) who is licensed or certified in another state; or 6) an advanced practice registered nurse licensed by the state of Montana under Title 37, chapter 8.

Q: What is a designated treating physician?

A: A provider who is designated or formally approved by the insurer as the physician who will be coordinating the injured worker's care, according to the criteria in 39-71-1101 MCA.

Q: Can a mid-level provider (for example, Physician Assistant or Advanced Practice Nurse) be designated as a treating physician?

A: Yes. Any of the practitioners listed in the definition of a treating physician may be designated as a treating physician.

Q: What are the responsibilities of the "designated treating physician"?

A: As a designated treating physician you are responsible for: 1) coordination of all medical care; 2) providing timely determination of Maximum Medical Improvement (MMI), 3) Return To Work, work restrictions, job analyses, etc; 4) providing or arranging for treatment within the Utilization and Treatment Guidelines; 5) conducting or arranging for timely impairment ratings; 6) submission of necessary documentation to include the office notes and Medical Status Form after each office visit.

The DLI encourages insurers to work with the designated treating physician to schedule appointments and distribute the necessary documentation for the coordination and management of the care. Treating physician offices may contact the insurer's claims examiner assigned to the claim for clarification.

Q: How will I know if I am the designated treating physician?

A: For injuries on or after July 1, 2013, the insurer must send formal notification by letter, email or fax to the new designated treating physician, the previous treating physician and the injured worker. The new designated treating physician has 10 days to decline the designation.

Q: How do I request being the designated treating physician? How do I request to not be the designated treating physician?

A: If you think you should, or should not, be the designated treating physician on the file, contact the insurer's claims examiner assigned to the injured worker.

Q: When will a claim be designated with a treating physician?

A: Prior to the designation of a treating physician by the insurer, the injured worker has the choice of treating physician. Any time after the claim is accepted by the insurer, the insurer may designate the treating physician.

Q: What are common reasons for the insurer to designate a treating physician and transfer care for an injured worker?

A: Common criteria for designating a treating physician and transferring care for an injured worker may include: 1) provider specialty is not appropriate for the injured worker's injury or OD; 2) the injured worker's medical management is at a maintenance level and does not require specialty care; Medical provider does not agree to be the treating physician; 3) medical provider is not compliant with requirements of the designated treating physician role; 4) same or similar services are available locally; 5) the injured worker requests a change in treating physician and the request is appropriate; 6) medical provider's treatment is consistently outside the U&T Guidelines without prior authorization; 7) the injured worker relocates to a different geographic community; 8) medical provider is no longer in practice; 9) medical provider releases or discharges the injured worker from his/her care; 10) medical provider loses hospital privileges; 11) any time after acceptance of the claim, the insurer may designate or approve a treating physician.

Q: If I am the designated treating physician, am I responsible for determining the injured worker's Maximum Medical Improvement (MMI) and scheduling the Impairment Rating appointments?

A: Yes. If the designated treating physician is uncomfortable with giving an Impairment Rating, the provider may schedule it with another physician who has the training to provide an Impairment Rating. The DLI encourages insurers to work with the designated treating physician to schedule these appointments and distribute the necessary documentation for the coordination and management of the care. Designated treating physician offices may call the insurer's claims examiners for assistance in coordinating care.

Q: If I am the designated treating physician, am I responsible for providing the required documentation of MMI and Impairment Rating determined by another physician?

A: Yes, according to the law, this is one of the responsibilities of the designated treating physician. If the designated treating physician is not the physician documenting the Impairment Rating, then the provider should inform the insurer's claim examiner who will be providing those services. The designated treating physician's office may call the insurer's claims examiners for assistance.

Q: If I am the designated treating physician, am I responsible for approving the MMI and Impairment Ratings determined by another physician?

A: The law provides that you determine the date of MMI and either conduct or arrange for the impairment rating determination. The insurer may ask you, as the designated treating physician, whether you agree with the findings of a physician to whom you have referred the injured worker. If you do not agree, you may be asked to submit your rationale with objective medical evidence to the insurer.

Q: What happens when the injured worker needs more than one physician for multiple injuries?

A: Until a treating physician is designated, the medical providers reasonably necessary to treat an injured worker are paid at 100% of the DLI's fee schedule. Insurers have indicated they will only designate one treating physician at a time on a claim.

Q: Does the treating physician designation apply to on-call / covering or other providers within the group practice?

A: No, insurers have indicated they will only designate one treating physician at a time on a claim. The law requires designation of individuals and once the insurer designates the treating physician, all other medical providers who are not designated are paid at 90% of the fee schedule.

Q: Will there be more than one designated treating physician?

A: No, insurers have indicated they will only designate one treating physician at a time on a claim. The law requires designation of individuals rather than a group practice. Once the insurer designates the treating physician, all other medical providers who are not designated are paid at 90% of the fee schedule.

Q: If a designated provider requests a consult with another provider, will he/she no longer be considered the designated treating physician?

A: If it is a consultation only, there would not be a change in status of the designated treating physician. If the consulting provider wants to assume care of the injured worker's medical management, the insurer would need to authorize the change.

Q: If the patient has a treating provider and is referred to us and is seen by our surgeon who recommends surgery, can the treating physician at that point be changed to the surgeon until the patient is healed from the surgery and then be relinquished back to the other provider?

A: Yes, if the insurer agrees to designate the surgeon as the treating physician until the injured worker is healed from the surgery and released to the care of the original designated treating physician. Some surgeons have been quite clear they never want to be the treating physician. Some surgeons firmly believe they need to determine restrictions, MMI, etc. If a surgeon has accepted the role of a designated treating physician, the insurer may expect the surgeon to remain in that position at least through MMI. The surgeon takes over all the responsibilities of the designated treating physician per the criteria in 39-71-1101, MCA.

Q: Does all treatment information from referred medical providers have to go to the treating physician now?

A: Yes. Notes for any medical services provided are required and should be provided to the treating physician or their designee, including recommendations for temporary or permanent medical restrictions.

The Department encourages the insurer to provide all treatment information to the designated treating physician or to coordinate the exchange of all treatment information between the designated treating physician and previous or referred medical providers.

Medical Status Form

Q: What is the purpose of the Medical Status Form?

A: The Medical Status Form's primary purpose is a communication tool between the physician, the injured worker and the employer for the current work abilities of the injured worker in returning the worker to either part time or full-time work. The treating physician or designee must complete the form after each visit. The Medical Status Form also provides sufficient information to the insurer for adjusting the claim and paying the appropriate benefits.

Q: How will medical providers obtain the medical status form?

A: The form and instructions for completing the form are available from DLI electronically or in duplicate hard copy free of charge. The electronic PDF online version of the [form](#). To obtain duplicate hard copies of the form contact Celeste Ackerman at 406-444-6543 or celeste.ackerman@mt.gov

Q: Can medical providers alter the format of the form to more easily comply with their operating systems?

A: Medical providers have permission to have the form programmed into their medical records system as long as the name of the form remains the same and all the data fields are included in the same order as DLI's form. Insurers and medical providers have requested a universal form that is easily recognized by all stakeholders.

Q: Who is responsible for filling out the Medical Status Form?

A: By law the treating physician or designee is required to complete the Medical Status Form after each visit. DLI believes by submitting the form to the insurer within 24 hours of the visit, the insurer will ask fewer follow-up questions or won't request additional information about the treatment or expectations for return to work. A delay in providing the form may result in a delayed payment.

Q: If I am not a treating physician, am I responsible for filling out the Medical Status Form?

A: No, by law a treating physician or designee is required to complete the Medical Status Form after each visit. DLI believes by submitting the form to the insurer, the insurer will ask fewer follow-up questions or won't request additional information about the treatment or expectations for return to work.

Q: Is the Medical Status Form considered a "job analysis"?

A: No. The Medical Status form provides information to insurers, injured workers and some of it can be shared with their employers about their abilities and restrictions with regard to the injured worker returning to either part time or full-time work as well as the next scheduled appointment.

A Job Analysis describes specific job duties and tasks and is either provided by the employer or is an analysis prepared by a Certified Rehabilitation Counselor (CRC) on a specific job. DLI recommends insurers have a job analysis of the time of injury job be completed as soon as possible to establish a base line for returning the injured worker back to work.

Q: Is it the patient's responsibility to take the form to the provider to be filled out?

A: No. The provider should already have the form. It is available [here](#)

Q: Is the patient/employee's signature required on the form?

A: No, however, DLI encourages the treating physician to review the information on the form with the patient. The patient's signature acknowledges receipt of the information and supports the General Guideline Principle of Patient Education in the Montana U & T Guidelines.

Q: There are three parts to the Medical Status form. Page one is for the insurer, page two is for the injured worker and page three is for the employer. Can one form be used for both?

A: Page one contains all the information necessary for the claims examiner to adjust the worker's compensation claim, including medical information between the insurer, patient and provider that is confidential under Montana law. Page 2 is for the injured worker to have for his records concerning his work abilities and his medical care. Page 3 is for the employer to know the injured worker's abilities so that a return to work program may be set up within the scope of those abilities. This page does not include any medical information that may not be shared with the employer.

Q: Will the Medical Status Form eliminate additional forms required by insurers?

A: The form should eliminate additional forms required by the insurer that request the same information. If the provider has provided the same information on the Medical Status Form the provider may bill the insurer for answering those same questions again. Insurers may request additional information not contained in the Department's form and the provider may bill for their time to answer those questions using MT001.

Q: Is the Medical Status Form required if the patient is a no show?

A: No. The provider needs to inform the insurer of any no shows immediately.

Payment Levels

Q: How much will I be paid for an Impairment Rating?

A: DLI sets reimbursement levels for workers' compensation physicians and other medical services. All workers' compensation insurers and self-insurers are required to pay medical providers based on that fee schedule, unless a Managed Care Organization (MCO) or Preferred Provider Organization (PPO) contract is in place. Under the current DLI fee schedule Impairment Ratings are paid at usual and customary charges of the physician.

Q: How much will I be paid for emergency / urgent / acute care?

A: Prior to the insurer's designation or approval of a treating physician, all services are paid at 100% of DLI's fee schedule. Many insurers will not designate a treating physician on claims that resolve relatively quickly and therefore, many bills will be paid at 100% of the fee schedule.

Q: Who sets the fee schedule?

A: The DLI sets the fee schedule for services provided to injured workers and the schedule is required to be used by all workers' compensation insurers or the insurers' benefit payers. This includes the Montana State Fund, private workers' compensation insurance carriers, and self-insured employers.

Q: Who designates the physician reimbursement levels (110% or 90%)?

A: The base fee schedule is set by the Montana Department of Labor and Industry by administrative rule. Montana law provides for two variations in the reimbursement levels, based on the insurer's designation of treating physician (110%) or a medical provider (90%) who has been referred to by the insurer designated treating physician. The insurer responsible for the claim will determine if a treating physician will be designated on the claim and will notify the medical provider of this decision. Many insurers will not designate a treating physician on claims that resolve relatively quickly and therefore, many bills will be paid at 100% of the fee schedule.

Q: Would other professional services (i.e. PT, lab, and x-ray) provided by the group-owned service of the treating physician get 110% of the fee schedule?

A: No, the law requires designation of individuals rather than a group practice. Once the insurer designates the treating physician, all other medical providers who are not designated are paid at 90% of the fee schedule. Updated 09/19/2011.

Q: How will insurers pay for designated treating physician owned MRI services? ASC services? Lab services? Diagnostic and therapeutic testing?

A: The tiered reimbursement levels apply to professional services only under the [Montana Professional Fee Schedule](#) found on the DLI website. Reimbursement levels are not determined by who owns a facility.

Q: Can the insurer designate a treating physician for a limited purpose or a limited time, so that the provider may receive 110% of the fee schedule?

A: While the insurer has discretion in who to designate as a treating physician for the reimbursement level, the purpose of the increased reimbursement is to increase compensation for the treating physician who is responsible for the coordination of care within the Utilization and Treatment Guidelines until MMI is reached. This includes determining physical restrictions, return to work abilities, approval of job analyses, and conducting or arranging for timely impairment ratings.

Q: How much will I be paid for services provided before the insurer's designation of treating physician?

A: Prior to a treating physician being designated on a claim, medical providers are reimbursed at 100% of the workers' compensation fee schedule.

Q: Do the payment levels apply to all cases?

A: When a treating physician is designated by an insurer on a workers' compensation claim then the physician is paid at 110% of the workers' compensation fee schedule. Many insurers will not designate a treating physician on claims that resolve relatively quickly and therefore, many bills will be paid at 100% of the fee schedule.

Montana Workers' Compensation Utilization & Treatment Guidelines

Q: Where did the Utilization & Treatment Guidelines come from?

A: The Montana Department of Labor and Industry was required under the law to put guidelines in place for workers' compensation medical treatments. The DLI convened a panel of active Montana workers' compensation medical providers to review available guidelines throughout the US, both nationally and in individual states. They unanimously recommended a set of guidelines based on the existing Colorado Workers' Compensation Medical Treatment Guidelines, supplemented with the ACOEM Guidelines for use in Montana.

Q: How often are the Guidelines updated?

A: DLI is required to review the Guidelines at least annually for updates and changes.

Q: If an ICD-10 code is not listed in the Montana Guidelines, will the bill be denied?

A: No, the ICD-10 codes listed in the Montana Guidelines are the most common diagnosis but are not all inclusive. Providers should use the correct diagnosis based on the injured workers reason for seeking medical care. NOTE: If an injured worker is seeking treatment for an unrelated condition, a bill or service may be denied.

Q: What services need to be prior authorized?

A: The best way to access information on what requires prior authorization is to reference Administrative Rule [24.29.1621](#), that supports the Guidelines. If treatment or procedures are recommended by the Guidelines, and treatment is provided in accordance with the Guidelines, prior authorization is unnecessary unless the Guidelines specify otherwise.

To view a list of procedures or treatments that require authorization, you can enter the Guidelines website and use the search engine by typing in "prior authorization". To view durations and frequency limits for services, find the appropriate guideline and search the treatment or procedure you want to view.

There are four main situations in which prior authorization is required and they are as follows. When treatments or procedures are requested that: 1) are not specifically addressed OR recommended by the Guidelines for a body part that is covered by a guideline; 2) are after MMI; 3) are beyond the duration or frequency limits set out in the Guidelines; 4) the Guidelines specifically require prior authorization before proceeding with the treatment.

Q: How do you change the approved or insurer designated treating physician?

A: Prior authorization is presumed to be granted if there is no response from the insurer within 14 days of the request. All objective medical findings and results should be submitted in a timely fashion to the insurer as documentation for treatment.

Q: When should services be prior authorized?

A: To assure payment, authorization should be received prior to the treatment, if the treatment or procedures meet one of the four above situations that require prior authorization. All objective medical findings and results should be submitted in a timely fashion to the insurer as documentation for treatment.

Q: Why would U&T Guidelines not permit payment?

A: The recommendations in the Guidelines are medical treatment guidelines that establish compensable treatment. The Guidelines help define treatment and services that are reasonable based on evidence-based medicine and are not guidelines for managing a claim. The Guidelines establish that a treatment is not payable when the treatment is not recommended in the Guidelines, because the treatment is not considered reasonable treatment.

Q: Why would a request for treatment under U&T Guidelines be denied?

A: Under the Guidelines, payment for treatment may be denied when the injured worker doesn't meet the selection or exclusion criteria for a given treatment. It would also be appropriate to deny treatment beyond the point that the injured worker is benefitting from treatment (unless the requesting provider has provided an explanation as to why continued treatment would be medically reasonable or necessary). Objective functional improvement is considered the goal of treatment. If there is no further functional improvement, claims examiners may question the value of continued treatment. Maintenance and palliative care are appropriate in certain situations but need to be supported under the Guidelines. All objective medical findings and results should be submitted in a timely fashion to the insurer as documentation for treatment.

Q: What do I do if treatment is denied?

A: If treatment is denied, you may request an [Independent Medical Review](#) by the DLI Medical Director. You must submit your request for review to DLI and notify the insurer of the request for review. For more information see [ARM 24.29.1641](#) -Independent Medical Review Process. The Medical Director has up to 14 days to make a recommendation. If there is no response within that time, the request for review is deemed to be denied and the parties can proceed to mediation.

Q: If Guidelines authorize 24 treatments, can they be denied prior to the completion of the maximum number of visits?

A: If a treatment guideline describes that a treatment's maximum duration is 24 treatments and the injured worker clearly has no functional improvement, at, for example, 18 treatments, as explained in the General Guidelines Principles, it is appropriate for the insurer to question why continued care would be medically reasonable or necessary. There could be confounding circumstances why the injured worker is not making progress; for example, co-morbid conditions can preclude an aggressive rehabilitation plan, the injured worker may have valid reasons why s/he could not participate with the rehab plan, or a recent non-compensable surgery could prohibit aggressive rehabilitation.

Q: Do the U & T Guidelines apply to all cases?

A: Yes. For injuries on or after 7/1/07, the U&T Guidelines establish compensable medical treatment for injured workers. For injuries prior to 7/1/07 the U&T Guidelines are considered reasonable care.

Q: What do we need to do to identify functional gain/improvement?

A: The General Guideline Principles found at the beginning of each chapter state: "Positive patient response results are defined primarily as functional gains that can be objectively measured. Objective functional gains include, but are not limited to, positional tolerances, range of motion (ROM), strength, endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings."

This doesn't mean that every injured worker must display all responses, but the list includes reasonable evidence of functional progress. All objective medical findings and results should be submitted in a timely fashion to the insurer as documentation of progress.

Q: What standards should physicians use to document functional gain as expected under the U&T Guidelines?

A: There are many appropriate tools available for physicians to measure a variety of the measurable gains listed above. Physicians are not held to any one tool.

Q: How should functional gain be documented?

A: There are many appropriate tools available for physicians to measure functional gains, however, if general objective improvements are seen - not merely patient reports of improvement or worsening - then it is likely there is progress resulting from treatment. A decrease in medication usage, ability to accomplish tasks the injured worker was previously unable to do, lessening of work restrictions are also examples of functional gain. "Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings." All objective medical findings and results should be submitted in a timely fashion to the insurer as documentation of progress.

Q: Can insurers require treatment outside the Guidelines?

A: Insurers may require the patient/employee to submit to an independent medical evaluation or functional capacities evaluation; however, the insurer cannot require treatment outside the Guidelines. The insurer may question the treating physician regarding prescribed treatment within the Guidelines.

Q: If surgery is included as a recommended treatment under the Guidelines, can a physician assume the surgery will be paid for before other less complicated types of treatment are administered?

A: No. The General Guidelines Principles indicate that the Guidelines are to be administered in a progressive manner and are designed so that certain requirements need to be met prior to initiating additional treatment. Less invasive, simpler, and less costly treatments are to be followed before more complex and expensive alternatives. The Guidelines are all written in this progressive step-by-step manner. A provider is not to proceed to more complex treatments unless the clinical indications are present. And nothing in the guidelines requires that all treatments recommended be provided. As noted in 24.29.1591(3)(a) of the Administrative Rules of Montana, in cases where treatments or procedures are recommended by the Guidelines, and treatment is provided in accordance with the progressive nature of the Guidelines, prior authorization is unnecessary unless the Guidelines specify otherwise.

Workers' Compensation Coverage / Benefits / Maximum Medical Improvement

Q: If the injured worker leaves the state and is not at Maximum Medical Improvement (MMI) is s/he required to return for treatment for that determination?

A: Generally, if an injured worker moves out of state and needs to continue or complete their treatment, the medical provider in their new location would be appropriate to determine MMI and provide an Impairment Rating as long as the 6th Edition is used. The insurer will work with the injured worker to obtain a treating physician in the area s/he is residing for ongoing care and determination of MMI.

Q: Does reaching MMI mean there are no more medical benefits available?

A: MMI per Montana statute is defined in the following way: "Medical stability", "Maximum Medical Improvement", "maximum healing", or "maximum medical healing" means a point in the healing process when further material functional improvement would not be reasonably expected from primary medical services.

In some instances, medical treatment for the work injury may be necessary on an ongoing basis but the majority of injured workers will not require post-MMI treatment. As a result of new changes to the Administrative Rules, treatment after MMI will require prior authorization.

Q: What is covered by workers' compensation?

A: Montana workers' compensation law provides for reasonable and necessary medical care, with no co-payments or deductibles from the injured worker, as a result of a compensable industrial injury or occupational disease – typically an accident occurring during the "course and scope" of work or a disease resulting from work activities over more than one work shift. Workers' compensation also provides for a level of replacement for lost wages, should the injuries and recovery prevent the person from being able to work. Workers' compensation does not replace full wages but provides a benefit level based on the state average weekly wage. Workers' compensation is not designed to make someone "whole" after an industrial accident but offers prompt provision of medical and lost wage benefits to help them recover.

Q: How do I know if the treatments provided are for a workers' compensation claim? What if the patient doesn't have a claim number?

A: If you are the first medical provider subsequent to an injury, a claim number may not be assigned because the First Report of Injury (FROI) may not yet be filed or processed by the insurer. Once the

insurer receives the FROI, all workers' compensation claims are assigned a claim number by the insurer. If a patient presents and indicates it is a workers' compensation claim, they may or may not have a claim number. If they do not have a claim number, or do not know who their work comp insurer is, the provider may contact the Department at 406-444-6543.

Q: What do I do if I do not want to accept a workers' compensation patient?

A: If you do not want to accept a workers' compensation patient, advise the patient and contact the claims examiner assigned to the injured worker.

Q: What is MMI and why does the Claims Examiner request this information?

A: MMI per Montana statute is defined in the following way: "Medical stability", "Maximum Medical Improvement", "maximum healing", or "maximum medical healing" means a point in the healing process when further material functional improvement would not be reasonably expected from primary medical services. A claims examiner needs the MMI date to process the potential impairment benefits that may be payable to the injured worker. In some instances, medical treatment for the work injury may be necessary on an ongoing basis but the majority of injured workers will not require post-MMI treatment. As a result of the adoption of the Guidelines, treatment after MMI will require prior authorization.

Q: What is maintenance medical care, and is it payable for workers' compensation injuries?

A: The General Guideline Principles that precede the content of each chapter of the Guideline Reference Care beyond MMI in the following way: "MMI should be declared when a patient's condition has plateaued to the point where the authorized treating physician no longer believes further medical intervention is likely to result in improved function. However, some patients may require treatment after MMI has been declared in order to maintain their functional state." Treatment beyond MMI requires prior authorization. All objective medical findings and results should be submitted in a timely fashion to the insurer as documentation for treatment.

Q: Why is early Return to Work or Stay at Work so important?

A: The ability to return to work, or stay at work, is an indication of the restoration of a set of life functionalities in the recovery process. The Guidelines state, "Return to work is therapeutic assuming the work is not likely to aggravate the basic problem or increase long term pain. ... Even if there is residual chronic pain, return to work is not necessarily contraindicated." Most people see an improvement in their medical recovery if they are able to participate in their family and work activities.

Q: What type of medical file documentation does the Claims Examiner need to adjust a claim?

A: Insurers need the following information to properly adjust a worker's compensation claim: 1) office notes for each evaluation and treatment including the objective medical findings related to injury, functional status, treatment plan and subsequent changes to medical treatment including referrals related to the injury; 2) list of ongoing medications related to injury; 3) the completed Medical Status Form.

Q: Is the Lockhart lien still valid under the new workers' compensation bill?

A: Yes, there is no change to the law regarding the Lockhart Lien.

60 Month Termination of Medical Benefits

Q: Is the termination of medical benefits 60-month law, 39-71-701(1)(f), from date of injury or last date of service?

A: Except for permanent total disability claims, the new law terminates medical benefits 60 months from the date of injury or diagnosis of an occupational disease. Medical benefits for permanent total disability and prosthetics are available for the injured workers' life. The vast majority of injuries requires only medical attention and do not involve significant time away from work.

Reopening of terminated medical benefits

A claim that has been terminated under 39-71-704 (1)(f) may be considered for reopening per 39-71-717 (1) A petition to reopen medical benefits that terminate under 39-71-704 (1)(f) must be reviewed as provided in this section. The Petition to Reopen Closed Medical Benefits may be found [here](#).