All About Claims

Colorado Department of Labor & Employment
Division of Workers' Compensation
Communications Unit, 633 17th St., Suite 400
Denver, CO 80202-3660
www.coworkforce.com/dwc/

January 2006 **Volume 24**

All About Claims is a newsletter published by the Colorado Division of Workers' Compensation designed to provide information to claims handlers. Please send comments or suggestions for future topics to JoAnne Ibarra at 303.318.8790 or by e-mail to JoAnne.Ibarra@state.co.us.

"Snapshots" of Division of Workers' Compensation NEW Workers' Compensation Rules of Procedure effective January 1, 2006

Provisions of HB 05-1139 and Workers' Compensation Rules of Procedure (WCRP) impacted

- Affects various sections of § 8-43-409, § 8-43-304, § 8-43-101, and § 8-43-203
- Takes effect July 1, 2005 & applies to acts occurring on and after that date.
- Gives DOWC director flexibility regarding hearing time and procedures; imposes daily fines up to $250 for 1st time violators & $250 to $500 for subsequent violations for noninsurance; removes limit on fines previously limited to periods after notification and director's obligation to suspend fines upon proof of coverage; clarifies director's authority to fine carriers who knowingly and repeatedly violate the WC Act; requires director to promulgate rules for determining fines; establishes new reporting and record keeping requirements for employers and carriers (EDI); provides that 25% of fines collected go to WC Cash Fund & 75% to General Fund.

Abbreviated Overview of 7 CCR 1101-3, Workers' Compensation Rules of Procedure (WCRP), Rules 1 through 18

- Arabic numbering replaces Roman numerals in rule numbering; outline format revised and more logical rule sequence used

✓ **Rule 1: General Rules and Provisions**: sets forth definitions and other provisions that apply throughout the rules.

✓ **Rule 2: Surcharge**: addresses the premium surcharge paid by carriers and self-insured employers.

✓ **Rule 3: Insurance Coverage**: includes requirements for reporting, notification, and fines.

✓ **Rule 4: Carrier Compliance**: concerns DOWC audit of insurers' claims handling, statutory and rule compliance and enforcement when non-compliance is determined.

✓ **Rule 5: Claims Adjusting**: includes requirements for filing and adjusting claims, filing documents with the DOWC, how benefits are calculated, and when benefits are to be paid.

✓ **Rule 6: Suspension**: procedures required to modify terminate or suspend benefits.

✓ **Rule 7: Closure and Reopening**: involves claim closure, reopening, and the approval of settlement agreements; requires a proposed Order to Show Cause to accompany request to close claim for failure to prosecute; enlarges Director discretion in closing claims for lack of prosecution; requires submission of a completed checklist when seeking Director approval of settlement agreement; provides procedure for reopening claim is the same for either party, e.g., using DOWC form, moving party requests other party to reopen claim; form does not have to be filed with DOWC; reason for

reopening with supporting documentation tendered to other party; a medical report is no longer required. If other party agrees to reopen, DOWC notified & claim reopened, otherwise, moving party proceeds to hearing.

✓ **Rule 8: Hearing Rules**: Office of Administrative Courts (OAC) in the Department of Personnel and Administration has adopted hearing rules.

✓ **Rule 9: Division of Workers' Compensation Dispute Resolution**: includes discovery, ADR, prehearing & settle ment conferences; filing of pleadings and other documents, handling of claim files, trust deposits and surety bonds for noninsured claims; consolidation of claims and penalty procedures before the Director.

✓ **Rule 10: Medical Utilization Review**: sets out process for utilization review pursuant to §8-43-501; permits provider under review to submit written statement; names of the persons to perform review sent to the parties; ten days afforded to raise issue of conflict and request change; if not timely raised, allegation will not be considered; defines what is considered a conflict; no discovery permitted to examine issue of a conflict.

✓ **Rule 11: Independent Medical Examination**: includes requirements for and details of the DIME process; still per mits DIME's limited referral to another doctor for essential testing; identifies situations concerning whether a particular doctor can perform DIME; permits DIME doctor to request additional $ if case is complex or involves multiple body parts; increases amount to $250 DIME may keep if DIME is not cancelled timely or claimant does not appear or medical records are not submitted timely; at doctor request or determination by the Director, DIME doctor can be classified tem porarily inactive and not assigned any cases.

✓ **Rule 12: Permanent Impairment Rating Guidelines**: provides details and instructions for impairment ratings.

✓ **Rule 13: Accreditation**: contains information on Level I and Level II accreditation process including process for revoking accreditation; clarifies that to be accredited, doctor must satisfactorily complete examination given by the DOWC & removes reference to "passing" exam; clarifies when accreditation expires; requires doctor initially to provide 3 impairment rating reports to DOWC for review; provides that such information is for use by DOWC and confidential.

✓ **Rule 14: Major Medical Fund and Subsequent Injury Fund**: includes applications for admissions to the funds, appeals, terminating benefits, offsets and clarifies the Director is a party in all fatal cases.

✓ **Rule 15: Vocational Rehabilitation**: concerns VR process for injuries that occurred prior to July 2, 1987 at 4:16 pm.

✓ **Rule 16: Utilization Standards**: includes definitions of standard terminology, administrative procedures and dispute resolution procedures. These rules are used in conjunction with, and to implement, the Medical Treatment Guidelines and Medical Fee Schedule (Rules 17 & 18).

✓ **Rule 17: Medical Treatment Guidelines**: changes primarily involve language revision, formatting and renumbering.

✓ **Rule 18: Medical Fee Schedule:** is required by statute; sets out maximum allowable fees for health care and related services; major change is addition of medical facility fee schedule; DOWC seminars will focus on related methodology (see DOWC web site at http://www.coworkforce.com/dwc/)

Highlighted changes: Rules 3, 4, 5, 6 and 9

Rule 3:

- New provisions added as a result of the passage HB 1139. Rule 3-1(E) allows the director to designate persons to conduct pre hearing conferences regarding default in insurance per §8-43-409(1). Rule contains new provisions setting out a fine structure for operating business without required workers' compensation insurance. Increased fines based on whether the violation is first or second offense; sets out amount per day that increases as the time without insurance increases; filing requirement for coverage rejection by corporate officers streamlined.

Rule 4:

- New provisions added. Rule 4-1(C)(6) provides that insurer may be required to go back and correct deficiencies involving the payment of benefits for all claims covered by audit period if compliance ratios are below 90%; DOWC given authority by HB 1139 to impose fines against an insurer for pattern and practice of poor claims adjusting. Rule 4-1(C)(6) also provides that audit will be performed on insurers to establish baseline of compliance with statute and rule. Subsequent audits could result in fine imposition if adjusting practices do not meet acceptable levels. It is anticipated that additional rulemaking will occur in this area.

Rule 5:

- Rule 5-1 reflects the change in statute (HB 1139) that as of July 1, 2006, all first reports and notices of contest must be filed electronically (EDI or Internet); allows Director to exempt an insurer from that requirement.
- Rule 5-2 provides First Report must be filed within 10 days of notice or knowledge of an injury that meets the require ments for filing with DOWC. First Report to be filed with DOWC when: (1) injury or disease causes permanent physical impairment (2) injury or disease results in lost time from work in excess of 3 shifts or 3 calendar days (3) upon the contraction of certain occupational diseases that are listed in the rule even if they don't result in lost time (4) and any time a claim is denied.
- Rules 5-2 (C) and (D) address positions on liability ("admit or deny"). An insurer must file a position on liability with in 20 days after a First Report is, or should have been, filed. (Historically, an insurer had to file a position statement with in 20 days of notice or knowledge of the injury). The new provision requires a position statement if a First Report should have been filed. The rule defines the date a First Report should have been filed as the last day it could have been filed time ly (a violation could result from not filing a position on liability even where a First Report was not filed).
- Rule 5-2 (E) requires that a claim must be established before DOWC can accept a position on liability. Rule 5-2 (F) identifies the information that is to be submitted monthly by insurers in summary form.
- Rule 5-4 (C) addresses medical releases; also provides that exchanging information to evaluate/adjust a claim is not considered discovery.
- Rule 5-5 (A) allows evaluation information other than a worksheet to be attached to Final Admission.
- Rule 5-5 (I) requires that admission of medical impairment must be a whole number.
- Rule 5-6 requires that claimant receive the initial payment of temporary benefits within 5 days of the date of the admission and first installment of permanent disability be received within 5 days of the date of the admission.
- Rule 5-7 (C) requires that scheduled and whole-person impairment benefits be paid concurrently.
- Rule 5-11 (A) provides that benefit amounts are based on a seven-day week.
- Rule 5-11 (B) requires a Final Payment Notice (a DOWC form) be submitted on every claim after it closes, including those that close on a Final Admission, Final Order or Stipulation. This would include closure by Final Settlement. This new requirement will be applied to Final Admissions and other closures filed or occurring after 1/1/06.

Rule 6:

- Rule 6-1 (A) (4) requires a copy of the inquiry to the treating doctor regarding the claimant's ability to perform modified duty be sent to the claimant. The claimant has 3 business days from receipt of the offer to return to work in response to an offer of modified work.
- Rule 6-4 (C) provides that if the insurer files a petition to suspend, modify or terminate benefits, and the claimant does not respond, the Director may grant the petition. In the past the petition was automatically granted if the claimant did not object.
- Rule 6-7 provides that temporary benefits can be terminated by filing an admission based on a third-party settlement if "documentation substantiating" that claimant received money damages from a third-party settlement is submitted. The Rule no longer specifically requires the fully executed settlement agreement to be submitted.
- Rule 6-8 (B) allows the Director to order reinstatement of temporary benefits if they were improperly terminated, with out requiring an objection from the claimant.

Rule 9:

- Most of the provisions of new Rule 9 were previously in former Rule VIII and have not been changed.
- Rule 9-5 (A) now provides that SIF be designated as trustee for trust deposits and surety bonds ordered on claims when an employer is uninsured; directs that the total present value due of claim should be calculated "using the best information available" and put into trust. Trustee to pay claim using the monies deposited. The amount placed in trust can be amend ed. The trustee is not subject to penalties or other actions.
- Rule 9-5 (B) provides as an alternative to placing money into a trust, the uninsured employer can post a bond. The employer is supposed to make payments on the claim, but if they fail to do so the bond can be executed for making the pay ments.
- Rule 9-6 provides that two or more claims can be consolidated for "hearing or other purposes" if ordered by an ALJ or the Director.
- Rule 9-7 streamlines the process for the Director to consider a penalty. If necessary, the Director may hold a hearing or may refer the matter for hearing.
- Rule 9-8 removes attorney requirement to file Notice of Intent to Practice; recognizes distinction between entering an appearance at DOWC and entering an appearance at OAC; addresses withdrawal of counsel and substitution of counsel in closed and open claims.

Limited Overview of changes to 7 CCR 1101-4, Rules Governing the Issuance of Self Insurance Permits Under the Workers' Compensation Act

- Elimination of some extraneous language and addition of other language to help clarify rule.
- Addition of new language to clarify Part 3 (5): requiring that all existing self-insured permit holders report all changes subsequent to the initial application concerning acquisitions, mergers, spin-offs, creation of new subsidiaries, and changes with Federal Employer Identification Numbers (FEIN), a minimum of 30 days prior to the effective date of the change for approval if the holder intends to add coverage under the existing self-insurance permit.
- Addition of a new condition: Part 5 (B) (3): requiring that revoked self-insured employers wait at least five years from the date of revocation before reapplying for a self-insurance permit.
- Addition of a new condition: Part 5 (B) (4): requiring that a revoked permit holder must continue to provide annual claims data and any other requested data to the Executive Director until it is determined that all liabilities have been met.
- Addition of a new condition: Part 6 (A)(6): requiring that each permit holder provide "other" annual data as requested by the Executive Director.
- Addition of new language to clarify Part 6 (B)(2): Advises self-insured permit holders that the Executive Director will notify a permit holder of any required change in security or when a change in insurance requirements is necessary.

Limited Overview of changes to 7 CCR 1101-6, Rules Governing the Issuance of Cost Containment Certificates under the Workers' Compensation Act, Title 8, Article 14.5

- Elimination of some extraneous language and addition of other language to help clarify rule.
- Addition of language to provide that, prior to the issuance of certification, the Board will consider employer claims management practices including accident investigation and early return to work/modified duty programs.
- Addition of language to provide that, prior to the issuance of certification or renewal of certification, the Board will consider three full policy years of loss data and hours worked by all employees during each of those policy years.
- Addition of details regarding the appeal process for denied certification and renewal applicants
- Addition of initial job/task training in the list of specifications that the Board will consider in evaluating applications for certification.

Colorado Division of Workers' Compensation
Communications Unit
633 17th Street, Suite 400
Denver, Colorado 80202-3660
M300300040