ALL ABOUT CLAIMS

DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

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We took a summer hiatus from publishing the newsletter, but we're back and looking forward to establishing better levels of communication with the workers' compensation adjusting community.

There are a few items which we'd like to bring to your attention due to the direct impact which these have on claims handling practices.

COMPLIANCE REVIEW

Rule IV(O), Compliance Review, was adopted by the Director and will go into effect on September 30, 1993.

The rule provides a mechanism for the Division to review claim files of insurance carriers. The purpose is to ensure that benefits are calculated accurately, paid timely and that claims are otherwise handled in accordance with the Workers' Compensation Act and the Rules of Procedure. The review will be confined to claims for injuries arising on or after July 1, 1991 and will be conducted by the Carrier Practices Unit of the Claims Services Section.

The initial recommendation that the Division have such a mechanism had its origins in the John Lewis study commissioned by the legislature in 1987. Most of the recommendations of the Lewis study culminated in major revisions to the statute contained in SB 91-218. In order to accommodate its intent of litigation reduction, the legislature declared that active claims management should be practiced by the Division.

Considerable research and discussion has gone into the development of the review process. In addition to utilizing the resources of the experts at the Department of Labor and Employment and the Attorney General's office, we enlisted the aid of claims adjusting supervisors from the eight insurance carriers with the largest claims volume.

It is clear that this rule provides an enforcement mechanism, but it is the Division of Workers' Compensation's stated intent that this be a practical tool for educating and informing claims adjusters and reinforcing good behaviors.

At the time of this newsletter, the basis for selection of insurance carriers for review has not yet been determined. The Carrier Practices Unit recently returned from a visit with Mid-Century (Farmers) Insurance who was anxious to submit and make history as the first carrier to be reviewed under this rule. We intend to accept this kind offer and are truly appreciative of their cooperation and invitation.

If you would be interested in having a representative come to your office and explain the rule, please call Ernie Dunn, Manager of Carrier Practices, at 764-2950.

IMPAIRMENT RATING GUIDELINES REGARDING EXTREMITIES

An emergency rule which clarified how extremity ratings are applied using the AMA Guides to the Evaluation of Impairment, third edition (revised) in conjunction with the schedule (§8-42-107(2)) was signed into effect on September 17, 1993. Specifically, it requires that the carrier use the rating provided by the authorized treating (and Level II accredited) physician in admitting for impairment to an extremity. Simple, huh? In reviewing this issue, we found it to be fairly complex. But let's begin at the beginning.

The Director of the Division of Workers' Compensation is required to establish an impairment rating system which is based on the third edition (revised) of the AMA Guides. In reviewing the Guides, you will note that there is no method for rating impairment for partial loss of use of the (1) forearm at the elbow, (2) joints at the wrist and ankle, (3) leg at the knee, and (4) toes at the metatarsal. However, impairment may be rated at the proximal joints of the fingers or toes, as a whole hand or foot, or at the upper and lower extremities.

A practice had developed with one of the insurance carriers which we noted in our review of final admissions. The practice was to apply the rating from the physician to a body part other than that which the physician had rated. This resulted in a significant difference in payments between insurance carriers who admitted for permanency based on the treating physician's rating and those who interpreted the rating to fit the schedule. On the average, the difference amounted to about $1300.00 per case.

Following recommendations given at public hearing that a conversion table be developed to harmonize the Guides with the schedule, the Director asked Dr. Katherine Mueller, Medical Director, to review the Guides to determine whether

findings at a follow-up hearing on September 14, 1993. The following is an excerpt from her testimony:

> After reviewing the entire book, I am submitting this summary. I found three schedules which had four options each to choose from and seven scheduled ratings which had had no impairment rating in the AMA Guides. Given the significant bureaucratic complications from attempting to use this translation, I do not recommend it. It would be costly from an administrative point of view, and I do not believe it reflects the authors' of the Guides weighting of specific joints.

It is important to note, that while the Guides do not track the schedule joint for joint, ratings which are provided in accordance with the Guides are already weighted. That is, if an individual receives an injury to the knee and is given an impairment rating of 10% of the lower extremity, the 10% is a reflection of impairment to the extremity as it relates to loss of function of the knee.

An argument can be made for either interpretation. The Director, however, is charged with implementing the statute and ensuring consistent application. In the absence of legislative clarity, it is necessary to return to the legislature's intent. The legislative declaration as found under §8-40-102 is clear and provides for the "quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers without the necessity of any litigation..." Therefore, while perfect harmony of the statutes is not possible, the Director believes that through this interpretation, the greater goals of SB 91-218 are accomplished.

IME EMERGENCY RULE

The IME Emergency Rule which went into effect on June 1, 1993 and answered the question of "who pays?" for all IME applications on or after that date, expired on September 1, rule (which was in effect for three (3) months from the date of adoption). If a dispute arises relative to the "who pays?" question, the Administrative Law Judges from the Division of Administrative Hearings are empowered by statute to rule on who should pay in a specific case. Anyone needing a judge to make a determination should call or drop by Room 140[illegible] and speak to the DOA docketing staff. It is important to note that the permanent rules with regard to all other IME procedures, such as the cost of the IME, the application process, etc., remain intact. The Director has indicated that the above information on dispute resolution will be made available soon through a mailing to insurance carriers and attorney practitioners. Non-represented claimants will receive an informational packet in the event a dispute arises as to the payment of a division IME. Keep in mind, nothing precludes the carrier from entering into an agreement for payment of the IME or electing, in the first instance, to obtain a binding IME.

FIRST REPORT PROCESSING AT THE DOWC

Recognizing the desire of our data entry unit to provide you with timely and efficient service, please note impediments which may significantly delay or preclude the assignment of a W.C. number:

1) no average weekly wage
2) no date of birth
3) no FEIN number
4) no date of injury
5) no policy, carrier, adjusting code or block number
6) no transmittal sheet
7) use of the wrong transmittal sheet
8) failing to provide insurance company address or fax number on transmittal sheet

Currently, the Division data entry operators call the carrier in an effort to obtain information over-the-phone. It is not known how long they can continue to perform this service, and we ask that carriers be mindful of our limited resources and desire to serve.

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