ALL ABOUT CLAIMS

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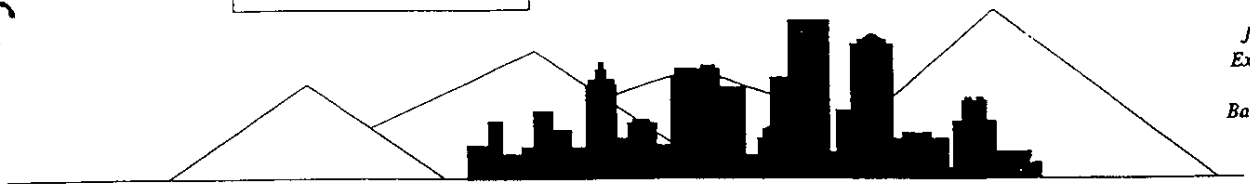

DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION
CLAIMS SERVICES SECTION

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The articles in this newsletter are compiled to enhance information exchange between the DOWC Claims Services Section and the adjusting community of the Colorado workers' compensation system. In this issue you'll find an article denoting carriers who demonstrate outstanding performance in specific areas of the compliance review as well as an update on Utilization Review following the Nofio decision. Also, check out our new write-in column and an update on the Romero decision and its impact on Lump Sum awards. Your advice on how to make this publication useful and informative is always appreciated. Please direct your comments or questions to the DOWC, Attention: JoAnne Ibarra, at 1515 Arapahoe Street, Denver, CO 80202 or call me direct at (303) 575-8816.

Got a Question?
by JoAnne Ibarra, Manager, Claims Services Section

The DOWC Director and Claims Services personnel frequently receive letters from the public requesting information or enforcement on issues related to claims handling practices. We'd like to share some of those inquiries and responses with you in order to "simplify the processing of claims, reduce litigation and better serve the public." (See §8-43-217, C.R.S.). For the purpose of this column, we invite questions from claims adjusting personnel. While a definitive answer is not always possible (as the facts of each claim will vary), we hope to provide a forum for discussion. As always, we are happy to respond to your questions over the phone.

Dear Ms. Kozelka:

I am writing to request that you investigate problems that I am consistently having with insurance adjusters who are insisting that my client's cases are closed when they try to obtain additional medical care. As you know, just because a worker has reached maximum medical improvement, does not mean that their case is closed or that they do not require additional medical care in the future.

When my clients have attempted to return to their doctors for additional medical assistance after maximum medical improvement, but without the case being closed, the doctors have refused to see my clients on the basis that the insurance adjusters are claiming that the cases are closed.

Because of this behavior by the adjuster, my clients go for quite a period of time without any additional medical care and then the insurance adjusters attempt to give the *coup de grace* by filing a motion to have my clients' cases closed for failure to obtain any medical care.

Barbara J. Furutani, Esq.

Dear Ms. Furutani:

You have advised that claims adjusters are denying authorization for medical treatment after maximum medical improvement (MMI) has been attained based on erroneous information that a claim has been closed. If a claimant has timely objected to a Final Admission of Liability, and the claim has not been closed by order, then the claim remains open.

Some carriers have internal processes for identifying inactive claims and re-diarying them for infrequent review. However, this is not to be confused with the actual open/close status of a claim as defined by statute and rule. If adjusters are confusing this, or misleading the public as to the basis for denying further medical care, then, it is appropriate that the issue be addressed. Please feel free to contact the Claims Services Section relative to specific instances in which this has occurred. We would be happy to contact the carrier for the purpose of educating and discussing behavior modification in this area. The question of whether medical treatment should be authorized after MMI has been achieved in the absence of definitive medical information is, I believe, a separate issue and must be addressed on an individual basis.

JoAnne Ibarra on behalf of the Director

Carrier Practices Unit Initial Summary of Compliance Review Outcomes
by Dee Hyslop, Carrier Practices Officer, Claims Services Section

The Carrier Practices Unit of the Division has been conducting compliance reviews of carriers, self-insured employers, and third-party administrators over the past year. We are encouraged by the level of exchange we have experienced with carriers and with the commitment expressed in the responses to our compliance reports. We have also enjoyed meeting the many managers and adjusters whose offices we invaded, and having the opportunity to have open exchanges.

Our emphasis has been and continues to be on education. In this manner, we believe we can better serve the community and impact positively the greatest number of cases. Many of you have asked about penalties. At this time, we would only consider penalties in extreme cases of noncooperation with the reviews and the recommendations expressed in the reports.

After over a year of conducting the compliance reviews, we thought it would be helpful to exchange information about outstanding performances in specific measured categories. The following is intended to acknowledge the outstanding performances in the industry to date of those who have been the subject of a compliance review and is provided with the carriers' permission. Whether a carrier is listed here or is not listed in other categories is not a reflection of the carrier's performance in other areas.

Forms--Colorado Compensation Insurance Authority (CCIA) and CNA Insurance performed outstandingly in filing properly-completed forms as provided in Rule XI(A). This is an important area in particular when considering if improperly-completed forms are returned to the carrier, the time elapsed will affect whether a position statement is filed timely.

Position Statement Filed Within 20 Days--Liberty Mutual Insurance can claim a stellar performance in this area, averaging fewer than 12 days to state a position. The number of days to state a position is counted from the date the carrier had notice or knowledge of an injury to the date the Division receives the position statement. If you are a self-insured employer or administer claims for a self-insured employer, you must consider that notice to the employer representative is notice to the carrier.

Position statements should be mailed to the Division daily. For some carriers there was a lapse of several days between the date on the position statement and receipt by the Division. We do recognize that coupled with the timely filing of position statements is the prompt initial payment of benefits.

Calculation of Average Weekly Wage--Claims Management, Inc (CMI) is being recognized because not only did they have a strong performance in reconciling wages, but they make a practice of providing the actual wage history upon which the admitted AWW is based when filing the initial admission. This aids the Claims Services Section in our oversight role and can serve to avoid disputes.

Establishing an accurate average weekly wage is an important area under SB 218, for the accurate delivery of benefits and for calculation of the permanent impairment award when it involves a whole person rating.

Timely and Consistent Payment of Compensation Benefits--Kemper Insurance had an exceptional performance in this area. King Soopers and Mid-Century/Farmers Insurance also had strong performances in this area.

Payments were considered late if the initial payment was not made within 20 days of notice and subsequent payments were not made at least once every two weeks, as required by §8-42-105(2), or if payment was not mailed on the date of the admission, pursuant to Rule IV(E). Payments should be mailed at least three days prior to the last date the payment covers to avoid a potential dispute over whether benefits were paid when due.

Timely Payment of Medical Benefits--Kemper Insurance had an exceptional performance in this area: medical payments were made on average within 10 days. Aetna paid on average within 13 days; CNA Insurance in 14 days.

Payment of medical bills is required within 30 days. If payment is denied, notice must be sent within 30 days to the provider and parties explaining why payment is denied. Untimely payment of medical bills affects all facets of the community. Potential disputes can be avoided with proper handling of medical bills.

Exchange of Documents--Aetna consistently certified that its documents were exchanged with the parties, in accordance with Rule XI(B).

Utilization Review
by Rebecca Greben, UR Coordinator

A recent decision by the Colorado Supreme Court in CCIA v. Nofio, 886 P.2d 714 (Colo. 1994), has eliminated much of the uncertainty surrounding the Division's Medical Utilization Review ("UR") program. This program, codified at §8-43-501, C.R.S., was created in 1988 to provide parties to a worker's compensation case with a tool to evaluate whether medical care rendered to a claimant by a specific provider is appropriate and/or necessary according to accepted professional standards. The "tool" consists of a panel of three independent medical providers who review the treatment given to the claimant. Their assessment can lead to one of three outcomes as ordered by the Division Director: (1) removal of the health care provider from the specific worker's compensation case; (2) removal of the provider from the case PLUS retroactive denial of medical fees previously paid to the provider (i.e., the provider must reimburse certain fees as ordered); or (3) retention of the provider on the case.

The Nofio case addressed the question of whether a claimant is entitled to a hearing when he/she wishes to appeal the Director's order in a UR case. The UR statute states that the only party entitled to a hearing on appeal of a UR order is the medical provider, and ***only*** in cases where the provider's fees were retroactively denied. Other parties may appeal, but are entitled only to a "review of the record"-- a procedure whereby the UR case file and additional written arguments are submitted to an administrative law judge who then decides whether the Director's order was supported by "substantial evidence." However, during the last few years other Colorado courts have held that essentially any party appealing a UR order is entitled to a hearing. The fact that these decisions appeared to conflict with the requirements of the statute led to some confusion and uncertainty regarding the UR program.

In Nofio, the Colorado Supreme Court essentially upheld the language of the statute and reinterpreted the findings of those lower court decisions. In short, the statute should be enforced as written: only medical providers who are ordered to reimburse fees may request a hearing on appeal of that order. All other parties--including the insurance carrier--are entitled only to a review of the record. Because the Colorado Supreme Court is the highest forum in the state, its decision in Nofio finally resolves the confusion over how a UR appeal may proceed.

The Division would be glad to send a representative to your office to present and explain the UR program to claims managers and adjusters, medical staff, or any other appropriate personnel. If you wish to schedule such a visit or if you would like further information about the UR program, please contact the DOWC's Utilization Review Coordinator, Rebecca Greben, at (303) 575-8844.

Tribute to Ernie Dunn
by Dee Hyslop

As most of you know, during the last year Ernie Dunn retired, and we would like to take this opportunity to acknowledge the tremendous contribution Ernie has made to the Division, to the Claims Services Section, and to the workers' compensation community at large. While contributing to education within the Division and community and assisting in formulating policy and procedures for carrying out the mission of the Division, Ernie was able not only to impart his analyses and knowledge, but to provide a valuable overview grounded in the twenty-six years experience of history and evolution of the workers' compensation law. He managed to elevate the level of experience and response of those around him. Ernie is presently tickling trout on the Arkansas River. We miss him.

Lump Sum Task Force
by Mary Miller, Carrier Practices Officer, Claims Services Section

Section 8-43-406 of the Workers' Compensation Act of Colorado, C.R.S. (1994 Cum. Supp.), provides, "At any time after six months have elapsed from the date of injury, the director, in the exercise of discretion, ...may order payment of all or any part of the compensation awarded in a lump sum, or in such manner as the director may determine to be for the best interests of the parties concerned...."

A Lump Sum Task Force was convened by DOWC Director Barbara Kozelka on March 23, 1995, to address specific concerns raised by workers' compensation practitioners on the processing of lump sum applications for injuries arising on or after July 1, 1991.

Task force members were drawn from the insurance and claimant representative ranks and included Connie Kellner from TIG, Mark Zoltay from the Colorado Compensation Insurance Authority, and Tom Permenter from Liberty Mutual. Marshall Fogel, Bill MacDonald and Michelle Holland presented perspectives from the claimants' bar. JoAnne Ibarra, Harry Ferris and Mary Miller attended on behalf of the Director.

The following is a list of questions addressed by the task force:

1. Are lump sums for scheduled impairment processed any differently than an award for medical impairment under SB 218?

2. Should a full lump sum be granted if a carrier files a Final Admission of Liability and the claimant objects to the admission based on an issue other than the impairment award (e.g., Grover medical benefits, disfigurement, etc.)?

3. There exists the possibility that medical impairment awards can be reduced through the Division IME process. Should lump sums ever be granted (including the initial $10,000.00) while the issue of medical impairment is under dispute?

4. If the claimant gets the initial $10,000.00 lump sum and applies for a lump sum for the remainder, how is it calculated?

5. Must the claimant request the initial $10,000.00 in writing? May the carrier automatically pay it so the file can be closed?

6. Why must any lump sum amount over $10,000.00 be approved by the Division? May the parties agree on payment without approval?

7. Is there any basis for awarding a lump sum for medical impairment benefits over and above the $10,000.00 referenced under §8-42-107(8)(d)?

8. Should a full lump sum be granted if a carrier files a Final Admission based on a Division IME result and the claimant disputes the impairment award?

9. If the claimant does not object to the medical impairment rating but contends that he/she is permanently and totally disabled, should a lump sum be granted?

10. If a lump sum is granted based on an award for medical impairment and the claimant is later determined to be permanently and totally disabled, how are benefits applied?

11. Should a lump sum be granted when a claimant accepts a scheduled or impairment rating but contends there may be a psychiatric impairment which has not yet been rated? What other examples can you think of in which this could happen, and is there a negative consequence to either party?

Outcomes of the task force meeting have been forwarded to the Director. We will apprise you of the results following her review. Stay tuned....

Impact of Romero Decision on Lump Sum Discounts
by Barbara Kozelka, Director

Based on questions we have received on the calculation of discounts on lump sums involving P.T. awards (for injuries occurring July 1, 1991 to July 1, 1994), we have researched how the agency should proceed in light of the Romero decision. If you recall, the Court of Appeals in Romero v. the Industrial Claim Appeals Office, 19 Brief Times Reporter 330 (Colo. App. 1995), determined that C.R.S. Section 8-42-111(5), directing termination of benefits at age 65 in P.T. cases was "constitutionally arbitrary." We understand the Respondent/Insurer is seeking review by the Supreme Court, and the court has not indicated when or if it will grant review.

In formulating the division's position on calculating a discount for lump sums in these cases, we are required to treat Romero as precedent and calculate lump sums for P.T.s based on life expectancy rather than an age 65 cut-off date. Accordingly, we are currently implementing the following procedures:

1. In all cases with a pertinent DOI in which an Application for (P.T.) Lump Sum is presently pending before the director or a Lump Sum Award Order was issued on or after February 23, 1995 (the date of Romero), an Order to Show Cause will be issued to the Respondent/Insurer requesting it to either show good cause why the PT award should not be reopened for the purpose of (re)calculating the lump sum, or alternatively, set the matter for hearing before an Administrative Law Judge with the Division of Administrative Hearings.

If no response is received or the matter is not set for hearing within the specified time frame, an order to reopen the claim will be issued and a Lump Sum Award Order (or Amended Lump Sum Award Order, if appropriate) will be issued using life expectancy tables to calculate the cost of the lump sum.

2. For those cases in which a lump sum award order was issued prior to the effective date of Romero, a Petition to Reopen the P.T. award will be required.

Should you have questions with regard to this, please don't hesitate to contact either JoAnne Ibarra at (303) 575-8816 or Harry Ferris at (303) 575-8819.

IME Task Forces
by Al D'Antonio, Claims Manager, Claims Services Section

I believe it is safe to say that many have dealt with the IME process but few know much about it. The IME Program was established following the passage of S.B. 91-218. Sharon Elenburg has been in charge of the Program since its inception and presently has a staff of three. It is their job to recruit doctors to perform IME's, develop a system of rotation of qualified doctors, set the IME's and ensure compliance with the statute and rules of procedure. No easy task.

Two task forces are in place to assist the IME unit with various issues that arise:

The first is external and is composed of 20 individuals including physicians, attorneys, insurance and self-insured representatives and members of the division staff. This is a standing task force which meets on a monthly basis. Its mission is to address the issues that have been presented and to provide an on-going review of the IME process.

The second task force is internal and meets on an as-needed basis. It is composed of division personnel and its purpose is to implement the recommendations of the external task force. Information on these task forces may be obtained by calling the IME Unit at (303) 575-8840 or Rebecca Greben at (303) 575-8844.

NOTICE

LEVEL II RE-ACCREDITATION SEMINARS WILL BE HELD AUG-NOV OF '95

The Colorado Department of Labor and Employment, Division of Workers' Compensation will begin **Level II** Re-accreditation in August of 1995. Level II Physician's Re-accreditation will be presented as a series of seminars to re-accredit physicians who were Level II accredited in 1992.

The seminars will be held in Denver, Grand Junction and Colorado Springs from August to November 1995. Level II accredited physicians must attend one of the seminars in order to continue rendering impairment ratings on work-related injuries.

All Level II physicians will be sent registration information in June 1995. If you have any questions, please contact Faye Boyd, Accreditation Coordinator, at (303) 575-8756.