EMPLOYEE'S GUIDE

COLORADO
Department of
Labor and Employment

Division of Workers' Compensation

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THE INFORMATION IN THIS BOOKLET IS INTENDED TO BE GENERAL INFORMATION ON THE COLORADO WORKERS' COMPENSATION SYSTEM AND IS NOT INTENDED TO BE A SUBSTITUTE FOR LEGAL ADVICE

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WORKERS' COMPENSATION GUIDE FOR EMPLOYEES

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I. INTRODUCTION

Each state has its own laws regarding workers' compensation. The information in this booklet is intended to be general information about the Colorado workers' compensation system. It is not intended to be a substitute for legal advice.

In Colorado, the Division of Workers' Compensation does not pay benefits on a claim. Employers obtain workers' compensation insurance from private insurance companies. The insurance company pays the benefits. The Division of Workers' Compensation is a state agency. Some of the services that the Division provides are:

- ✓ To answer questions and provide information about workers' compensation
- ✓ To resolve disputes that might arise between you and your insurance company or employer
- ✓ To make sure that claims are properly handled

The Division maintains a file on your case, if lost time or disability resulted from the injury. You may come in on any business day, without an appointment, to review your file and ask questions about your case.

The Division of Workers' Compensation has a Customer Service Unit to assist you with information and answer questions regarding workers' compensation. See Page 22 for contact information.

Workers' compensation benefits are based on the date of injury. Since the laws change through the years, there may be different benefits depending on when you were injured. The information in this booklet applies to injuries at the time of the revision date on the front of this booklet. You may call Customer Service for information about the benefits for your date of injury.

If you are injured on the job, you should know that papers need to be filed correctly and within the right number of days. You must follow all rules and procedures or any benefits you may be entitled to receive, could be reduced or barred altogether.

The Division of Workers' Compensation is an administrative state agency and is not an insurance company. Workers' compensation insurance is provided by private insurers, including Pinnacol Assurance. Some large employers may provide their own insurance.

You can get a copy of the Colorado Workers' Compensation Act (the law) by accessing the Division's website or by contacting the Customer Service Unit. Division forms are available in Microsoft Word and Adobe Acrobat on our web site: http://www.colorado.gov/cdle/dwc/

II. GENERAL INFORMATION

WHAT IS WORKERS' COMPENSATION?

Workers' compensation is a type of insurance coverage that employers must provide for their employees. For employees who are injured on the job or develop occupational diseases, this insurance pays for medical expenses and partial wage replacement during periods of temporary disability. It may also provide permanent impairment benefits for those who qualify. There is no payment for pain and suffering under workers' compensation.

The cost of workers' compensation insurance is paid entirely by the employer and may not be deducted from an employee's wages. Workers' compensation insurance is the only disability insurance that Colorado employers must provide for their employees under state law.

WHICH EMPLOYERS MUST HAVE THIS INSURANCE AND HOW DO THEY GET IT?

Except for some specific exclusions, all employers are required by law to provide workers' compensation insurance coverage for their employees. Coverage may be purchased from any authorized insurance company. If an employer does not obtain workers' compensation insurance as required by law, the Director of the Division is authorized to impose fines, and/or issue a cease and desist order against the business to stop operations, until insurance is obtained.

Employers meeting specific qualifications, such as a minimum of 300 employees, may obtain permission from the Division of Workers' Compensation to become self-insured and pay their own benefits.

A contractor who contracts out any work to a subcontractor is liable for coverage for all workers of the subcontractor unless the subcontractor has obtained workers' compensation insurance coverage.

WHO IS COVERED BY THIS INSURANCE?

Most employees, both full and part-time, are covered under this insurance from the first day on the job.

WHO IS NOT COVERED BY WORKERS' COMPENSATION INSURANCE UNDER COLORADO LAW?

The following is only a partial list of occupations and/or individuals excluded from mandatory coverage under the Workers' Compensation Act.

- ✓ Certain casual maintenance or repair work performed for a business for under $2,000 per calendar year
- ✓ Certain domestic work, maintenance or repair work for a private homeowner that is not done full time
- ✓ Licensed real estate agents and brokers working on commission
- ✓ Independent contractors who perform specific for-hire transportation jobs
- ✓ Drivers under a lease agreement with a common or contract carrier
- ✓ Any person who volunteers time or services for a ski area operator
- ✓ Persons who provide host home services as part of residential services and supports
- ✓ Federal employees (covered under federal laws)
- ✓ Railroad employees (covered under federal laws)
- ✓ Independent contractors who are generally defined in the next paragraph

WHO ARE INDEPENDENT CONTRACTORS AND MUST THEY HAVE INSURANCE COVERAGE?

Generally, an independent contractor is a person who contracts to complete a specific project for another business for a set price. The independent contractor must be:

- ✓ Free from control and direction over the means and method o performing work
- ✓ Customarily engaged in an independent trade, occupation, profession or business related to the work being performed

While a business and an independent contractor may help establish independence in a written document, the actual facts will determine whether a particular worker qualifies as an independent contractor.

If the independent contractor has employees, workers' compensation insurance for the employees must be obtained.

Workers who qualify as independent contractors may not be able to claim workers' compensation benefits unless they have purchased workers' compensation insurance for themselves. If an independent contractor has chosen not to obtain workers' compensation insurance and is injured on a contract job, the maximum amount of recovery in civil court against the general contractor is $15,000 in damages.

If you have questions on independent contractors, call the Customer Service Unit.

II. WHEN AN INJURY OCCURS

WHAT SHOULD I DO WHEN I AM HURT?

In emergency situations, seek immediate medical attention at the nearest emergency room and then notify your supervisor in writing. A life or limb threatening injury means an injury that you believe threatens a portion of your body or your life in such a way that immediate medical care is needed to prevent your death or serious damage. In all other instances, notify your employer or supervisor, verbally and in writing, that you have been injured before obtaining any medical care. All injuries, no matter how small, should be reported to your employer.

By law, you must notify your employer in writing within four working days of an injury, even if you have advised them verbally. Keep a copy of your written notice. If you do not report your injury to your employer in writing within four working days, you may be penalized and lose up to one day's compensation for each day's delay, provided that your employer has posted a sign requiring four days written notice. **You may still file a claim for benefits even if you are late reporting the injury to your employer.**

Your employer is allowed to designate a medical provider for your care. If you choose to seek your own doctor, you may be responsible for payment of all medical bills. If your employer does not direct you to a medical provider, you may seek treatment from the provider of your choice. See Medical Benefits, section IV, for more information on medical providers.

WHAT SHOULD MY EMPLOYER DO AFTER BEING NOTIFIED THAT I HAVE BEEN HURT?

Your employer should file a report of the injury with its insurance company within ten days of your injury. This starts your workers' compensation claim. If your employer does not report your injury to the insurance company, you may file a claim directly with the Division of Workers' Compensation.

WHAT HAPPENS NEXT?

If you suffer an injury or occupational disease that causes you to lose more than three days or three shifts at work or results in permanent physical impairment, or death, the insurance company has 20 days from the date the injury is reported to the Division to notify you (or your dependents) whether benefits will be paid.

This decision will be either an Admission of Liability or a *Notice of Contest* (denial). The insurance company will put a carrier claim number and the adjuster's name and telephone number on the notice you receive. If you haven't missed three days of work because of your injury, no written decision is required from the insurance company. You should contact the adjuster with questions about your payments or the payment of medical bills, and the handling of your claim.

WHAT IF MY CLAIM IS ADMITTED?

If the insurance company determines that you are eligible for benefits, it will start paying for your authorized medical expenses as well as compensation benefits for lost time from work, if applicable. Compensation benefits are benefits paid directly to you to partially replace the wages you are unable to earn due to your injury. These benefits are paid every two weeks.

WHAT IF MY CLAIM IS DENIED?

The insurance company may deny your claim for a variety of reasons. An insurance company may deny a claim if the adjuster has reason to believe that the injury is not work related or if it is believed that they do not have complete and accurate information and further investigation is necessary. If this happens, you should contact the insurance company's adjuster to discuss this decision. You may be able to supply important information to assist in the process.

If the workers' compensation insurance company denies your claim, you may be responsible for all medical bills associated with the illness or injury. (You may then be eligible for coverage through your private health care insurance policy.) If you believe your claim has been incorrectly denied, there are several options available to you. (See Mediation Services, Prehearing, Settlement Conferences and Hearings, Section V.)

If your claim is denied and you want to request an expedited hearing, you must file an *Application for Hearing* within 45 days of the date of mailing of the Notice of Contest.

WHAT IF MY EMPLOYER FAILS TO REPORT MY INJURY TO THE INSURANCE COMPANY?

If your employer does not report your injury to the insurance company, or you do not receive an Admission of Liability, you may file a claim to protect your future rights. To do this, you may come to the Division of Workers' Compensation, Customer Service Unit to obtain the Worker's Claim for Compensation form, or call the Customer Service Unit to have the form mailed to you. It is also available on the Division website at: http://www.colorado.gov/cdle/dwc/ Keep a copy for yourself and send one to the Division at 633 17th Street, Suite 400, Denver, CO 80202-3626. After the Division receives your claim, a copy of the claim is sent to your employer's insurance company with a letter asking the insurance company whether it will admit liability and pay you your benefits. You will receive a copy of this letter that will indicate your workers' compensation claim number (WC#).

You should use this Division of Workers' Compensation claim number any time you contact the Division about your case.

You have two years from the date of your injury (or up to three years with reasonable excuse) to file a claim with the Division of Workers' Compensation.

If you don't file within this time, you may not get any benefits.

WHAT CAN I DO IF MY EMPLOYER DOES NOT HAVE WORKERS' COMPENSATION INSURANCE?

If your employer does not have workers' compensation insurance, you can choose between suing your employer in state court or filing a workers' compensation claim for yourself as explained in the preceding section. This is an important decision and you may wish to consult with an attorney before making it.

If you are awarded compensation and your employer did not have workers' compensation insurance, the employer may have to pay additional compensation.

If you have reason to believe your employer is not carrying workers' compensation insurance, you can call the Division of Workers' Compensation Customer Service Unit to report it, even if you have not experienced an injury.

IV. BENEFITS

MEDICAL BENEFITS

WILL MY MEDICAL EXPENSES BE PAID?

Once the insurance company files an Admission of Liability, or a final order for medical benefits has been awarded in your case, authorized medical providers must seek reimbursement from the insurance company. You should not be billed for the cost of their services or for the difference between what has been charged and what the insurance company paid. The medical provider should send all bills directly to the insurance company with the insurance company's claim number included. If you receive a bill for authorized medical services, you should forward it to the workers' compensation insurance company with the insurance company's claim number included. The insurance company is required to make payment or provide notification of the reason for nonpayment within 30 days. You may contact the Customer Service Unit if you need help.

Workers' compensation insurance pays for all reasonable and necessary medical expenses, if you receive care from a designated doctor or one who is authorized to provide care. (See "Who Chooses the Doctor"). If the designated doctor refers you to another doctor for treatment of your injury, and that treatment is reasonable and necessary, this medical treatment will also be covered. In addition, you will be reimbursed for all reasonable and necessary supplies and prescriptions, as well as mileage to and from medical appointments. If you go to a doctor who is not authorized, you may be responsible for those medical bills.

If the insurance company denies payment on certain medical bills, call your claims adjuster first to see if more information is needed.

If the insurance company still denies payment, see Mediation Services, Prehearing, Settlement Conferences, and Hearings, section V, for information on how to proceed.

WHO CHOOSES THE DOCTOR?

Your employer has the right to select the medical provider that injured employees must use.

Most employers must provide injured workers with a choice. If your employer has a written list of approved medical providers (a designated provider list), you may choose a treating doctor from this list.

If your employer does not properly designate a medical provider, you may choose your own medical provider. After the claim is filed, the insurance company may request that you be examined by another doctor of its choice, at its expense. If you do not go to this examination, the insurance company may ask the Division for permission to stop your benefits.

MAY I CHANGE DOCTORS?

You are entitled to obtain a one-time change of physician if you are within 90 days from the date of your injury and have not yet reached maximum medical improvement (MMI). The new doctor must be one of the doctors on the designated provider list provided by your employer. In order to obtain the one-time change of physician, you must file form WC3 with the employer's representative whose name is on the provider list. You may also provide a copy to the previous and new physician but you are not required to do so.

In addition, anytime during your claim but before closure of the claim, you may request permission to change to a doctor of your choice. You must complete form WC197 and submit it to the insurance adjuster on your claim. The insurance adjuster is not required to grant this request, however must respond to you in writing using the same form (WC197) within 20 days from the date your request was postmarked or hand delivered to the insurance company. If no decision has been given within 20 days, you can see the doctor of your choice. **If you change doctors without requesting permission in writing, the insurance company may refuse to pay these bills.** If you disagree with the decision of the insurance company, see Prehearing, Settlement Conferences, and Hearings, section V, for more information.

Notice of a One-Time Change in Physician C.R.S §8-43-404(5)(a)(III)	Request for Change of Physician C.R.S.§8-43-404(5)(a)(VI)
Injured workers are **entitled** to a one-time change of physician if all of the following criteria are met: • The notice must be provided within 90 days after the date of injury, but before reaching maximum medical • improvement (MMI) • A one-time change may only be made to another physician on the employer's designated provider list • The notice must be provided on form WC3 • This change is automatic and cannot be contested by the carrier	The criteria for requesting a change of physician (as distinguished from the one-time change of physician) are as follows: • Request may be made at any time (prior to closure of the claim) • Any physician provider may be requested, and does not have to be on the employer's designated provider list • The request must be made on form WC197 • The insurance company is also required to use form WC197 to respond to the request. If the insurance company agrees to the change, **or if no response is received within 20 days from the date the request was postmarked or hand delivered to the insurance company,** the request for the change of physician is granted.

WHAT IF I BELIEVE THAT THE MEDICAL TREATMENT I AM RECEIVING IS NOT NECESSARY OR APPROPRIATE?

If you believe that the medical treatment you are receiving is not necessary or appropriate, first attempt to resolve the situation with the insurance company.

If those efforts fail, you may:

- ✓ Contact the Customer Service Unit at the Division of Workers Compensation to see if they can assist you
- ✓ Request free mediation services at the Division of Workers' Compensation
- ✓ Request a free prehearing conference before an administrative law judge at the Division of Workers' Compensation
- ✓ Request a free hearing before an administrative law judge at the Office of Administrative Courts
- ✓ Request a Utilization Review of the medical care you have received. A fee is charged to cover the costs for a panel of physicians to review your case

Mediation, prehearing conferences, and hearings are described in section V. For information regarding the Utilization Review Process, contact the Customer Service Unit.

COMPENSATION BENEFITS

TEMPORARY DISABILITY

WILL I BE PAID FOR MY TIME OFF WORK?

If you miss more than three shifts, or three days of work due to a work-related injury or illness, you are eligible to receive compensation benefits. Wage replacement is calculated from the 4th shift, or day, you are unable to work due to the injury. Payment for the first three days missed is only made if you are still off work more than two weeks. This wage replacement is called temporary disability benefits and is paid to you by the insurance company or self-insured employer.

HOW LONG WILL I RECEIVE TEMPORARY DISABILITY BENEFITS?

There are two types of temporary disability benefits: temporary total disability (TTD) and temporary partial disability (TPD). Payment of TTD benefits stops when:

- ✓ You go back to regular or modified work
- ✓ You are given a written release to return to regular work by your authorized treating doctor
- ✓ You are given a written release by your authorized treating doctor to return to modified work, your employer makes you a written offer of such work, and you begin or refuse to begin

the work
- ✓ Your authorized treating doctor determines that you have reached maximum medical improvement (MMI). MMI means that the injury or disease causing your disability has become stable and no further medical treatment will improve the condition

If you work for a temporary help contracting firm, a business which hires people to work for a third party, you are entitled to receive only one written offer of modified work. Any future offers do not have to be in writing. The offer of work must be approved by your doctor. You are allowed at least twenty-four hours, not including Saturday, Sunday, or a legal holiday, to respond to the offer of work. If you do not accept the offer of work, your benefits may stop.

The insurance company should pay you temporary total disability benefits at least once every 2 weeks during the time you are unable to work. Temporary partial disability benefits are explained in the section, "What if I Return to Work Part Time?".

HOW MUCH WILL I BE PAID?

Your benefits will be two-thirds of your average weekly wage (AWW) up to the maximum amount allowed by law on the date of your injury. You may call the Customer Service Unit with any questions about average weekly wage. Average weekly wage includes: gross wages or salary, commissions, overtime, tips and per diem payments reported to the IRS, reasonable board, value of rent, housing and lodging, and the employee's cost of continuing the employer's group health insurance plan.

As long as the employer continues to pay any of the benefits, the value of those benefits is not included in the computation of average weekly wage. If as a result of your injury, you lose wages from another job that you held at the same time, the wages from the second job may also be included in your average weekly wage.

Workers' compensation benefits are not taxable. Some employers may continue to pay you your full salary for a period of time instead of having their workers' compensation insurance company pay you. You should check with your employer to see if this benefit plan is available.

CAN MY BENEFITS BE REDUCED?

Yes, benefits may be reduced if any of the following conditions are determined to be true in your case:

- ✓ You willfully failed to use a safety device
- ✓ You willfully failed to obey a reasonable safety rule
- ✓ You willfully misled your employer about your physical ability to do the job
- ✓ Your injury resulted from the use of drugs or alcohol
- ✓ You owe child support

- ✓ You return to work full or part time
- ✓ You or your dependents receive social security disability benefits
- ✓ You receive a pension from your employer or disability benefits paid, all or in part, by your employer
- ✓ You receive workers' compensation benefits for the same injury from another state
- ✓ You receive unemployment insurance benefits

The actual amount of the reduction of benefits is based on your case.

You must provide written notice to the insurance company of:

- ✓ A return to any employment
- ✓ Any other source of income that might reduce compensation benefits (such as Social Security disability benefits).

This notice must be sent to the insurance company or self-insured employer within 20 days after learning of the payment or award. Failure to report may result in the suspension of your benefits.

WHAT IF I RETURN TO WORK PART TIME?

If you cannot return to full-time regular work due to your injury and you return to modified duty with reduced wages or reduced hours, you are eligible for temporary partial disability (TPD) benefits. These benefits are calculated at two-thirds of the difference between your average weekly wage at the time of your injury and your part-time earnings, not to exceed a maximum allowed by law. Temporary partial benefits continue until:

- ✓ You go back to work at your pre-injury wages
- ✓ You are given a written release by your authorized treating doctor to return to modified work, your employer makes you a written offer of such work, and you begin or refuse to begin the work
- ✓ Your authorized treating doctor determines that you have reached maximum medical improvement (MMI). MMI means that the injury or disease causing your disability has become stable and no further medical treatment will improve the condition

If you work for a temporary help contracting firm, a business which hires people to work for a third party, you are entitled to receive only one written offer of modified work. Any future offers do not have to be in writing. Your doctor must approve the offer of work. You are allowed at least twenty-four hours, not including Saturday, Sunday, or a legal holiday, to respond to the offer of work. If you do not accept the offer of work, your benefits may stop.

WHAT IF MY PAYMENTS ARE LATE OR MY BENEFITS STOP AND I HAVE NOT RETURNED TO WORK?

If your checks for workers' compensation benefits are late or stop coming and you think they should continue, contact your insurance adjuster.

If the insurance company does not start paying you again, and you believe you are entitled to more benefits, contact the Division of Workers' Compensation Customer Service Unit.

If you have been released to return to work by your doctor, but are not employed, you should file an unemployment insurance claim within four weeks. Failure to file within four weeks of your release to return-to-work date could result in the loss of some or all of your unemployment benefits. You will need to provide the Unemployment Insurance Section a copy of your return-to-work release. To file a claim, contact Unemployment Customer Service at 303.318.9000, or outside the Denver metro area,
at 1.800.388.5515.

WHAT HAPPENS IF THE INSURANCE COMPANY DOESN'T PAY MY BENEFITS, AS THEY SHOULD UNDER THE LAW?

You can ask the Division of Workers' Compensation to impose a penalty on the insurance company, if you believe the insurance company did not follow the law in paying certain benefits. Your request must be filed in writing within one year after you first knew or reasonably should have known that the law was not followed in a way that might result in a penalty. Your complaint will be reviewed and you will get a copy of the decision.

IF I AM READY TO RETURN TO WORK, DOES MY EMPLOYER HAVE TO GIVE ME A JOB?

The workers' compensation law does not require that your employer hold a job open or create one for you. However, the employer may have obligations to you under other state and federal laws.

PERMANENT IMPAIRMENT AND THE FINAL ADMISSION OF LIABILITY

IF I HAVE A PERMANENT IMPAIRMENT OR SOME LOSS OF WAGES, WILL I BE PAID FOR IT?

If you are unable to fully recover from your injury (for example, due to the loss of use of your hand), your authorized treating doctor will decide if there is any permanent impairment or will refer you to a doctor who will make this determination. The doctor will first determine if any functional impairment resulted from your injury. If there is impairment, the doctor will assign an impairment rating based on the "American Medical Association Guides to the Evaluation of Permanent Impairment", *third edition revised.* If the insurance company agrees with the rating, they will file a *Final Admission of Liability* and you will receive weekly benefits for a certain length of time as compensation for the disability. The weekly amount depends on your date of injury and the length of time depends on the total amount of money owed to you according to law.

There are 3 types of permanent impairment:

Scheduled Impairment: Loss of function affecting the toes, feet, legs, fingers, hands, arms, teeth, vision or deafness

Whole Person Impairment: Loss of function affecting body parts not listed on the schedule above, such as the spine, lungs and mental impairment

Permanent Total Disability: Inability to earn any wages

Except for permanent total disability, awards for permanent impairment do not include any wage loss that may have occurred as a result of the injury or disease.

Any award for permanent impairment is based on functional impairment as defined by the authorized treating physician and is usually limited to the part of the body that is affected.

If you have a scar or disfigurement that was caused by the injury and is exposed to normal public view, you may be entitled to additional benefits. The maximum award for disfigurement is determined by the date of the injury and the extent of the disfigurement. If you have questions about the procedure for requesting disfigurement benefits or permanent impairment benefits, please call the Customer Service Unit.

WHAT IS THE FINAL ADMISSION OF LIABILITY?

A Final Admission of Liability is a final statement from the insurance company about what they believe has been paid or is owed to you. This admission will show the amounts paid for all the benefits that you have received, and any other benefits that they plan to pay in the future.

If you receive a Final Admission of Liability from the insurance company, and you disagree with the Final Admission, you must object in writing to this admission **WITHIN 30 DAYS**. You should receive an *Objection to Final Admission* form attached to the Final Admission. If you do not receive an objection form, contact the Customer Service Unit at the Division of Workers' Compensation to obtain a form. Complete the objection form or write a letter, within 30 days, to the Division of Workers' Compensation, 633 17th St., Denver, Colorado 80202-3626, and send a copy to the insurance carrier or self-insured employer, stating that you object to this Final Admission of Liability.

You must also do the following, if this applies to your claim:

1. If you have any disputed issues, complete an Application for Hearing and file it within 30 days, to the Office of Administrative Courts, HOWEVER

2. If you disagree with either the date of Maximum Medical Improvement (MMI) or whole person impairment determinations* complete a Notice and Proposal to Select an Independent Medical Examiner form, within 30 days, and send it to the insurance carrier. You must propose the name of one or more doctors to conduct a Division Independent Medical Examination (IME), if one has not already been conducted

through the Division. You must first request a Division Independent Medical Examination.

*Note: If you disagree with a scheduled rating, you may proceed directly to hearing without an IME, but must mail or deliver an *Application for Hearing* to the Office of Administrative Courts within 30 calendar days of the date of the Final Admission.

If you do not follow the requirements and time frames listed above, your case will automatically be closed as to the issues that were admitted in the final admission.

WHAT HAPPENS IF I CAN NEVER RETURN TO ANY KIND OF WORK?

If you are permanently and totally disabled, you may be entitled to lifetime workers' compensation benefits. The weekly amount of these benefits is the same as you would receive for temporary total disability benefits. This benefit amount remains the same throughout your lifetime. However, social security or a disability pension may reduce your workers' compensation benefits.

IF I AM UNABLE TO RETURN TO MY OCCUPATION, WILL I RECEIVE HELP FINDING A NEW JOB?

Your employer or its insurance company is not required to help you find a job, but may voluntarily offer vocational rehabilitation benefits. You may be required to participate in a vocational rehabilitation evaluation. If you refuse an offer of vocational rehabilitation or an offer of suitable employment by your employer, you will not be entitled to permanent total disability benefits.

DIVISION INDEPENDENT MEDICAL EXAMINATIONS

WHAT IF I DO NOT AGREE WITH THE DOCTOR'S RATING?

If you disagree with the doctor's impairment rating or the date of maximum medical improvement, you may request a Division Independent Medical Examination (DIME). If you are objecting to a Final Admission of Liability, you must send in your objection and propose the name or names of a Level II accredited physician within 30 days of the date of the final admission. A Level II accredited physician has received special training through the Division of Workers' Compensation to evaluate permanent impairment under the law. The cost of this examination is $675.00 and is paid by the party requesting the DIME.

The following is a brief summary of the IME process.

1. The party requesting the IME (requester) must complete the *Notice and Proposal for Independent Medical Examiner* form. The requester must send this Notice to the other party. If you are the claimant,

the other party is the insurance carrier. If you are the insurance carrier, the other party is the claimant or claimant's representative, if applicable.

2. The parties have 30 calendar days to negotiate the selection of the Independent Medical Examiner (physician who will conduct the IME.)

The requester needs to obtain an *Application for Independent Medical Examination (IME*), form WC77, during this time.

3. If the parties agree on the Independent Medical Examiner, the requester must schedule the examination promptly with the physician. The requester must also complete the Application for IME form and submit this to the Division of Workers' Compensation and the other party.

4. If the parties do not agree on the Independent Medical Examiner, or there is no response to the Notice and Proposal, the insurance carrier must complete the *Notice of Failed IME Negotiation*, Form WC 165. A copy must be sent to the Division and the claimant.

a. The party requesting the IME shall have 30 days from the date of the failure to agree or respond, to submit an *Application for Independent Medical Examination (IME)*, Form WC77. Within 10 calendar days of receiving the Application, the Division will issue a list of three qualified physicians. The parties will be notified in writing of the names of the three physicians.

b. Upon receiving the list of three physicians, either party may request a summary of the business, financial, employment or advisory relationships that any of the doctors on the list may have with insurance companies or self-insured employers, or with the claimant. The party must send their request, in writing, to the Division IME unit with a copy to the other party. The Division IME Unit will obtain the information from the doctors and send it to the parties. This information may be used to assist the parties in deciding which doctor to strike. The requesting party then has 5 days to strike one name from the 3-doctor list and notify the other party. The other party then has 5 days to make their strike, and notify the Division's IME unit and the requesting party of the remaining name.

c. If neither party requests the summary disclosure information from the doctors on the list, the requesting party has 7 business days from the date the 3-physician list was issued to strike one name from the list and notify the other party. The opposing party then has 5 business days to strike another name, and notify the Division's IME unit and the requesting party of the remaining name.

d. Once the doctor is selected, the requesting party must schedule the IME examination with the selected IME physician within 5 business days of providing and/or receiving notice of the name of the physician,

and must notify the Division and the opposing party of the date and time of the examination.

e. If the parties do not complete this process in 15 business days (this time may vary depending on whether the doctors' disclosure information is requested), the Division will select one name and notify the parties.

5. The carrier must submit medical records to the physician and the other party at least 14 calendar days before the examination.

6. The claimant must notify the insurance carrier if a language interpreter is needed at least 14 calendar days before the examination.

7. The requester must make payment to the IME physician at least 10 calendar days before the examination.

8. The physician is required to mail the IME report to the parties and the Division within 20 days of the examination.

9. If the requester wishes to cancel the IME process, the requester must contact the IME Section of the Division immediately.

If you have any questions, or need a *Notice and Proposal To Select An Independent Medical Examiner* and *Application for Independent Medical Examination (IME),* or any other forms, contact the Division of Workers' Compensation Customer Service Unit.

WHAT IF I AM UNABLE TO PAY THE COST OF AN IME?

If you are unable to pay the $675.00 cost of an IME, you may request that a judge of the Office of Administrative Courts determine whether you meet the financial requirements for indigence. The purpose is to ensure that no one is prevented from prosecuting a claim for benefits because of inability to pay the required fees.

If you are claiming inability to pay, you must file an *Application for Indigent Determination* (WC035 IME) within 20 days after submitting the *Notice and Proposal for Independent Medical Examiner* form. For additional information and forms, contact the Customer Service Unit.

FATALITY

WHAT IF SOMEONE IS KILLED ON THE JOB?

If someone is fatally injured on the job, workers' compensation provides weekly payments to the surviving dependent(s) and up to $7,000 for funeral expenses. The weekly amount of death benefits is calculated in the same way as temporary total disability benefits, and both are subject to a maximum benefit rate. However, death benefits are different in that there is also a minimum benefit rate. Payments are made for the lifetime of a dependent spouse, or until remarriage. If a surviving spouse remarries and there are no

dependent children, a lump sum equal to two years of benefits will be paid (less any previous lump sum payments or overpayments). If there are dependent children, the spouse's benefits are reapportioned among the remaining dependents. Any dependent child (including one to whom child support was paid or owed) may be eligible for payments until age 18, or until age 21 if the child is a full-time student. If there is no spouse or dependent child, other relatives such as a parent, grandparent, sister or brother, may be eligible for partial benefits.

These partial benefits are paid for six years. And finally, if the deceased is under the age of 21 with no dependents, payment of $15,000 is payable to the parents of the deceased. All of these benefits are reduced by fifty percent of the death benefits received by the dependents through social security.

LUMP SUM PAYMENTS

IF I AM AWARDED PERMANENT PARTIAL DISABILITY BENEFITS, CAN I GET THE MONEY ALL AT ONCE INSTEAD OF WEEKLY PAYMENTS?

If you receive a permanent partial disability award, you may request the automatic payment of up to $10,000 in a lump sum without waiving your right to prosecute the claim for additional permanent disability benefits. Or, you may request a maximum lump sum payment of up to $60,000 (in combined lump sum payments) on your claim. If you do this, you will be required to accept the amount of permanent partial disability benefits awarded.

Whenever a lump sum payment is requested, the lump sum will be reduced (discounted) by approximately 4% per annum. The Division's Claims Management Unit is available to provide lump sum calculations. If you have been awarded permanent total disability or dependent's benefits, your weekly payments will be reduced to account for the lump sum and a discount. If you have any questions, please contact the Claims Management Unit.

FULL AND FINAL SETTLEMENT

IS IT POSSIBLE TO SETTLE MY CLAIM?

You may settle all or part of your claim with your employer or the insurance company. The settlement usually involves giving up all or some of your rights to future workers' compensation benefits, including medical benefits, in exchange for an agreed upon amount of money. If the settlement amount is $75,000 or more, a written notice of the settlement agreement will be sent to your employer. Any settlement must be submitted to the Division of Workers' Compensation for approval.

REOPENING A CASE

MAY I REOPEN MY CLAIM AFTER IT IS CLOSED?

If you believe you need more medical care and/or temporary disability benefits after your claim has been closed, you may apply to reopen your claim. You

can file a *Petition to Reopen* directly with the insurance company. If the insurance company refuses to reopen the claim (or does not respond) you may file an application for hearing with the Office of Administrative Courts.

The request may be filed within 6 years from the date of your injury or 2 years from the date the last benefits (temporary, permanent or dependent) became due and payable, whichever is longer. If these dates are past and you need only further medical care, not temporary disability benefits, you may apply to

reopen your claim at any time within 2 years of the date the last medical benefits became due and payable. The only reasons you can use to reopen a claim are that an error, a mistake or a change in your condition has occurred.

If your claim is closed by written agreement between you and the insurance company and your settlement agreement states that you waive or give up your right to reopen your claim, then your settlement can ONLY be reopened on grounds of fraud or mutual mistake of material fact. If your claim is reopened for more temporary disability benefits, payments will be based on your wages at the time of the original injury. Reopening your claim will not affect the award of money already paid, unless the insurance company reopens the claim to recover an overpayment.

V. PREHEARINGS, SETTLEMENT CONFERENCES, AND HEARINGS

IF I DISAGREE WITH A DECISION OF THE INSURANCE COMPANY, OR IF THEY REFUSE TO PROVIDE BENEFITS I BELIEVE THEY OWE ME, WHAT DO I DO?

If you are unable to resolve any problem by discussing your concerns with the adjuster or your employer, you have the right to request a formal hearing on any disputed issue. Before you do that, or while you are waiting for a hearing, you can request a prehearing conference, or a settlement conference.

By using these services, you may be able to reach an agreement and avoid a formal hearing. If you are not able to resolve your dispute by agreement, you still have the right to go to a formal hearing.

WHAT ARE PREHEARING AND SETTLEMENT CONFERENCES?

A prehearing conference is an informal hearing conducted by an administrative law judge. A prehearing conference can be scheduled by any party and all parties are required to attend. The purpose of a prehearing conference is usually for a judge to resolve issues which must be decided before the parties attend a formal hearing. For example, issues which may be addressed at a prehearing conference include access to past medical records or requests by the insurance company to have the injured worker travel to a different city for an examination, postponement of a hearing or changing the issues for the hearing. A prehearing conference judge will not decide whether a claim is compensable or how much the injured worker should receive in benefits. Those issues must be decided at a hearing before the Office of Administrative Courts.

A settlement conference may be requested by either party, but will not be held unless all parties agree to participate. At a settlement conference, an administrative law judge will act as an impartial mediator helping the parties resolve the disputed issues in the case. During a settlement conference the judge does not have the power to decide issues or order anyone to do anything. The case will only be settled if everyone agrees.

Parties may also agree to have prehearing administrative law judges arbitrate (decide) a case. The parties will present their evidence to the judge, who will then decide the case. No appeal is permitted.

Both prehearing and settlement conferences can be conducted by telephone.

Anyone needing further information about mediation services, prehearing conferences, settlement conferences or arbitration should call the Customer Service Unit.

WHAT IS A HEARING?

A hearing is a formal legal proceeding where an administrative law judge decides what benefits, if any, must be paid, and decides any other issues. All parties may present evidence, including documents and sworn testimony of witnesses. A court reporter makes a record of the hearing. There is no jury. There is no charge for the hearing. Your failure to attend may result in an unfavorable decision, a delay in a decision on your claim, or the dismissal of your claim.

To request a hearing, you must file an *Application for Hearing* with the Office of Administrative Courts and send a copy to the insurance company. You may request this form by calling the Adjudication Docket. If you qualify for an expedited hearing, your hearing will be scheduled within 60 days of the date of the application. All other hearings are scheduled within 80-120 days. The Office of Administrative Courts has two docket offices, one in Denver and one in Grand Junction. You may ask for a hearing in Denver, Boulder, Colorado Springs, Durango, Fort Collins, Glenwood Springs, Grand Junction, Greeley or Pueblo. Call the Office of Administrative Courts docket section for current information on locations.

WHAT HAPPENS AFTER MY HEARING?

An administrative law judge will make a decision based upon the facts of your case and how the law applies to the facts. This written decision, called an order, will contain Findings of Fact and Conclusions of Law and will be mailed to all parties.

IF I DISAGREE WITH THE JUDGE'S DECISION WHAT CAN I DO?

If you want to challenge whether the administrative law judge made the right decision based upon the law and the facts of your case, you must follow a procedure called an appeal. The order mailed to you provides information on how to appeal. If you do not follow exact procedures within the correct number of days given to you, your appeal can be dismissed, and the administrative law judge's decision is final. Contact the Office of Administrative Courts docket section for questions and information regarding appeals.

You must file a *Petition to Review* WITHIN 20 DAYS from the date the order is mailed to you. A sample petition may be obtained from the Office of Administrative Courts. File the *Petition to Review* at the Office of Administrative Courts office listed on the order, and mail a copy to the insurance company's attorney.

In most cases, you will need to rely on transcripts of hearings for the Petition to Review. You must request a copy of the written transcript(s) of the hearing(s). To do this, you must write, or contact, the court reporter and order the transcript(s) at the time you file your Petition to Review.

You must pay the court reporter for this. If you are unable to pay for

preparation of a transcript, you may request that the Division pay for it. You will be required to complete an application for consideration by the Director.

WHAT HAPPENS NEXT?

When the transcript is done, or if no transcript is ordered, a letter will be sent to the parties setting time limits for filing briefs. If you have an attorney, a copy of this letter will not be sent to you, but will be sent to your attorney. A brief is a detailed statement of why you object to the order that the administrative law judge made and what evidence supports your position. After the parties file their briefs, the file will be given to the administrative law judge who wrote the decision. The administrative law judge may write another decision based on your appeal, or your file may be sent to the Industrial Claim Appeals Panel for its review.

The Industrial Claim Appeals Office will review your case and the administrative law judge's order and make its decision. It has 60 days from the date it receives your file to do this. A written copy of the decision that is made will be mailed to all parties.

If you disagree with this decision, you may appeal to the Colorado Court of Appeals within 20 days. Contact the Industrial Claim Appeals Office, 633 17th Street, Suite 600, Denver, Colorado 80202-3660, 303.318.8131 for the exact appeal process. Cases may be appealed from the Court of Appeals to the Colorado Supreme Court. The Supreme Court has the right to refuse to hear your appeal.

DO I NEED AN ATTORNEY?

You may see or hire an attorney at any time during your case. You have the right to make this decision. Workers' compensation hearings and procedures can be complicated. An attorney may be able to assist you with legal advice, investigation of your claim, production of witnesses at the hearing, conduct of your hearing, and communication with the insurance company's attorney. If you plan to hire an attorney, you should see one in time to help you decide whether to file for a hearing or conference and to allow for proper preparation.

Most attorneys take workers' compensation cases on a contingency fee basis. This means the attorney will take a part of the money awarded to you. An attorney's fee of 20% of the amount in dispute, or less, is considered reasonable in cases that are not appealed. You may request the Director to evaluate the reasonableness of any fee you believe is excessive.

IF I DECIDE NOT TO HIRE AN ATTORNEY, WHAT WILL HAPPEN?

You will have to represent yourself, or have a representative of your choice, at any mediation, prehearing conference, or hearing and you will be responsible for filing all the necessary papers. The Division of Workers' Compensation will give you information about how the workers' compensation process works, what benefits you may be entitled to, what forms to file and how to complete them. However, the Division of Workers' Compensation CANNOT

give you any legal advice or answer any legal questions you may have about your claim.

VI. OFFICES, ADDRESSES, AND PHONE NUMBERS

DIVISION OF WORKERS' COMPENSATION
633 17th Street, Suite 400
Denver, CO 80202-3660
Customer Service Unit
303.318.8700
Toll-free number (in state) 1.888.390.7936

Special Funds Unit
Major Medical, Subsequent Injury, and Medical Disaster Funds
Toll free number 1.800.453.9156

Internet Address: http://www.colorado.gov/cdle/dwc/

OFFICE OF ADMINISTRATIVE COURTS
1525 Sherman St, 4th Floor
Denver, CO 80203-1714
Adjudication Docket 303.866.5881

OFFICE OF ADMINISTRATIVE COURTS
222 South 6th, #414
Grand Junction, CO 81501
Adjudication Docket and Information 970.248.7340

VII. PUBLICATIONS

The Division of Workers' Compensation offers a variety of materials to the public regarding the system it administers. Publications are available on the Division's Web Page or can be requested by calling the Customer Service Unit.

- ✓ Overview of the Division of Workers' Compensation
- ✓ Workers' Compensation Guide for Employees
- ✓ Workers' Compensation Guide for Employers
- ✓ Workers' Compensation Guide for Adjusters
- ✓ Essentials of the Workers' Compensation Premium Cost Containment Program and Employer Certification
- ✓ Workers' Compensation Loss Prevention and Loss Control Program Manual
- ✓ Self-Insurance Information and Application
- ✓ Workers' Compensation Act
- ✓ Workers' Compensation Insurance Requirements for Employers

C.R.S. Section 10-2-127 states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies."

COLORADO DEPARTMENT OF LABOR & EMPLOYMENT
Division of Workers' Compensation
633 17th Street Suite 400
Denver, CO 80202-3660

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