

DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation

7 CCR 1101-3

WORKERS' COMPENSATION RULES OF PROCEDURE

Rule 5 Claims Adjusting Requirements

5-1 COMPLETION OF DIVISION FORMS

- (A) Information required on Division forms shall be typed or legibly written in black or blue ink, completed in full and in accordance with Division requirements as to form and content. Forms that do not comply with this rule may not be accepted for filing. Position statements relative to liability which do not meet Division requirements will be returned to the insurer.
- (B) Insurers may transmit data in an electronic format as directed by the Division.
- (C) Effective July 1, 2006, all first reports of injury and notices of contest that are required to be filed with the Division shall be transmitted electronically. Transmitted electronically includes either electronic data interchange (EDI), or via the Division's internet filing process. First Reports of Injury and Notices of Contest cannot be submitted via electronic mail.
- (D) The Director may grant an exemption to an insurer from filing electronically because of a small number of filings or financial hardship. Any insurer requesting an exemption from electronic filing may do so in letter form addressed to the Director. The request should provide specific justification(s) for the requested exemption. The letter should address whether an exemption is sought for only EDI or also for internet filing.

5-2 FILING OF EMPLOYERS' FIRST REPORTS OF INJURY

- (A) Within ten days of notice or knowledge an employer shall report any work-related injury, illness or exposure to an injurious substance as described in subsection (F), to the employer's insurer. An employer who does not provide the required notice may be subject to penalties or other sanctions.
- (B) A First Report of Injury shall be filed with the Division in a timely manner whenever any of the following apply. The insurer or third-party administrator may file the First Report of Injury on behalf of the employer.
 - (1) In the event of an injury that results in a fatality, or an accident in which three or more employees are injured, the Division shall be notified immediately.
 - (2) Within ten days after notice or knowledge by an employer that an employee has contracted an occupational disease listed below, or the occurrence of a permanently physically impairing injury, or that an injury or occupational disease has resulted in lost time from work for the injured employee in excess of three shifts or calendar days. An occupational disease that falls into any of the following categories requires the filing of a First Report of Injury:
 - (a) Chronic respiratory disease;
 - (b) Cancer;

- (c) Pneumoconiosis, including but not limited to Coal worker's lung, Asbestosis, Silicosis, and Berylliosis;
 - (d) Nervous system diseases;
 - (e) Blood borne infectious, contagious diseases.
- (3) Within ten days after notice or knowledge of a claim for benefits, including medical benefits only, that is denied for any reason.
- (C) The insurer shall state whether liability is admitted or contested within 20 days after the date the employer's First Report of Injury is filed with the Division. If an Employer's First Report of Injury should have been filed with the Division, but wasn't, the insurer's statement concerning liability is considered to be due within 20 days from the date the Employer's First Report of Injury should have been filed. The date a First Report of Injury should have been filed with the Division is the last day it could have been timely filed in compliance with paragraph (B) above.
- (D) The insurer shall state whether liability is admitted or contested within 20 days after the date the Division mails to the insurer a Worker's Claim for Compensation or Dependent's Notice and Claim for Compensation.
- (E) No statement regarding liability is required unless a Workers' Compensation claim number is assigned or a First Report of Injury should have been filed pursuant to paragraph (B) of this rule. The Division cannot accept a statement regarding liability without a First Report of Injury, Worker's Claim for Compensation, or Dependents Notice and claim having been successfully filed and assigned a claim number.
- (F) In the format required by the Director, each insurer shall submit a monthly summary report to the Division containing the following:
 - (1) Injuries to employees that result in no more than three days' or three shifts' loss of time from work, no permanent physical impairment, no fatality, or contraction of an occupational disease not listed in subsection (B) of the rule; and
 - (2) Exposures by employees to injurious substances, energy levels, or atmospheric conditions when the employer requires the use of methods or equipment designed to prevent such exposures and where such methods or equipment failed, was not properly used, or was not used at all.

5-3 INITIAL NOTICE TO CLAIMANT

At the time an insurer notifies the Division of its position on a claim, the insurer shall notify the claimant in writing of the insurer's claim number, the name and address of the individual assigned to the adjustment of the claim, and the toll-free telephone number of the adjuster.

5-4 MEDICAL REPORTS AND RECORDS

- (A) Medical reports on claims that have been reported to the Division shall be filed with the Division under the following circumstances:
 - (1) When attached to an admission of liability form, or a petition to suspend benefits, or

- (2) In connection with a request to the Division to determine the claimant's eligibility for vocational rehabilitation benefits or to review a vocational rehabilitation plan, or to review requests regarding the provision of vocational rehabilitation services, or
 - (3) When otherwise required by any other rule or the Act, or
 - (4) At the request of the director.
 - (5) A copy of every medical report not filed with the Division shall be exchanged with all parties within fifteen (15) working days of receipt.
- (B) For claims which are not required to be reported to the Division, the parties shall exchange medical information immediately upon request for such information by any interested party. Five (5) working days is considered to be a reasonable time within which to exchange information.
- (C) A party shall have 15 days from the date of mailing to complete, sign, and return a release of medical and/or other relevant information. If a written request for names and addresses of health care providers accompanies the medical release(s), a claimant shall also provide a list of names and addresses of health care providers reasonably necessary to evaluate/adjust the claim along with the completed and signed release(s). Medical information from health care providers who have treated the part(s) of the body or condition(s) alleged by the claimant to be related to the claim, during the period five years before the date of injury and thereafter through the date of the request, will generally be considered reasonable. If a party disputes that such request is reasonable or that information sought is reasonably necessary, that party may file a motion with the Office of Administrative Courts or schedule a prehearing conference. The request for and release of medical information as well as informal disclosures necessary to evaluate/adjust the claim are not considered discovery.
- (D) A party shall have 15 days from the date of mailing to respond to a reasonable request for information regarding wages paid at the time of injury and for a reasonable time prior to the date of injury, and other relevant information necessary to determine the average weekly wage. Any dispute regarding such a request may be resolved by the Director or an Administrative Law Judge. The request for and exchange of information under this Rule 5-4(D) is not considered discovery.

5-5 ADMISSIONS OF LIABILITY

- (A) When the final admission is predicated upon medical reports, such reports shall accompany the admission along with the worksheets or other evaluation information associated with an impairment rating. The admission shall specify and describe the insurer's position on the provision of medical benefits after MMI, as may be reasonable and necessary within the meaning of the Act. The admission shall make specific reference to the medical report by listing the physician's name and the date of the report.
- (1) The objection form prescribed by the Division as part of the final admission form shall precede any attachment.
- (B) An admission filed for medical benefits only, shall include remarks outlining the basis for denial of temporary and permanent disability benefits.

- (C) Admissions shall be filed with supporting attachments immediately upon termination or reduction in the amount of compensation benefits. An admission shall be filed within 30 days of resumption or increase of benefits.
- (D) For all injuries required to be filed with the Division with dates of injury on or after July 1, 1991:
- (1) Where the claimant is a state resident at the time of MMI:
 - (a) When an authorized treating physician providing primary care is not Level II accredited and has determined the claimant has reached MMI and has sustained any permanent impairment, such physician shall, within 20 days after the determination of MMI, refer the claimant to a Level II accredited physician for a medical impairment rating. If the referral is not timely made, the insurer shall refer the claimant to a Level II accredited physician for a medical impairment rating within 40 days after the determination of MMI.
 - (b) If the authorized treating physician determining MMI is Level II accredited, within 20 days after the determination of MMI, such physician shall determine the claimant's permanent impairment, if any.
 - (2) Where the claimant is not a state resident at the time of MMI:
 - (a) When an authorized treating physician providing primary care is not Level II accredited and has determined the claimant has reached MMI and has sustained any permanent impairment, within 20 days after the determination of MMI, such physician shall conduct tests to evaluate impairment and shall transmit to the insurer all test results and relevant medical information. Within 20 days of receipt of the medical information, the insurer shall appoint a Level II accredited physician to determine the claimant's medical impairment rating from the information that was transmitted.
 - (b) When the claimant chooses not to have the treating physician providing primary care conduct tests to evaluate impairment, or if the information is not transmitted in a timely manner, the insurer shall arrange and pay for the claimant to return to Colorado for examination, testing, and rating, at the expense of the insurer. The insurer shall provide to the claimant at least 20 days advance written notice of the date and time of the impairment rating examination, and a warning that refusal to return for examination may result in the loss of benefits. Such notification shall also include information identifying travel and accommodation arrangements.
- (E) For those injuries required to be filed with the Division with dates of injury on or after July 1, 1991, and subject to [§ 8-42-107\(8\), C.R.S.](#), medical impairment:

Within 30 days after the date of mailing or delivery of a determination of medical impairment by an authorized Level II accredited physician, or within 30 days after the date of mailing or delivery of a determination by the authorized treating physician providing primary care that there is no impairment, the insurer shall either:

- (1) File an admission of liability consistent with the physician's opinion, or

- (2) Request a Division Independent Medical Examination (IME) on the issue of medical impairment in accordance with Rule 11-3.
- (F) Within 20 days after the date of mailing of the IME's report determining medical impairment the insurer shall either admit liability consistent with such report or file an application for hearing. This section does not pertain to IMEs rendered under [§ 8-43-502, C.R.S.](#)
- (G) The insurer may modify an existing admission regarding medical impairment, whenever the medical impairment rating is changed pursuant to a binding IME, an IME selected in accordance with RULE 5-5(E); or an order. Any such modifications shall not affect an earlier award or admission as to monies previously paid.
- (H) For those injuries required to be filed with the Division with dates of injury on or after July 1, 1991, and subject to [§ 8-42-107\(2\), C.R.S.](#) scheduled injuries:
 - (1) The time requirements as set forth in Rule 5-5(D) apply.
 - (2) Within 30 days after a determination of permanent impairment from an authorized Level II accredited physician is mailed or delivered, or a determination by the authorized treating physician providing primary care that there is no impairment is mailed or delivered, the insurer shall either:
 - (a) File an admission of liability consistent with the physician's opinion, or
 - (b) Set the matter for hearing at the Office of Administrative Courts.
- (I) When an insurer files an admission admitting for a medical impairment, the insurer shall admit for the impairment rating in a whole number. If the impairment rating is reported with a decimal percentage, the insurer shall round up to the nearest whole number.
- (J) This section (J) applies to claims with a date of injury on or after July 1, 2008. A carrier may not reduce a claimant's temporary total disability, temporary partial disability or medical benefits because of a prior injury, whether work-related or non work-related.

If a permanent impairment rating is reduced on an admission pursuant to section 8-42-104(5)(a), a copy of the previous award or settlement shall be attached to the admission and must establish that the award or settlement was for the same body part. If a permanent impairment rating is reduced on an admission pursuant to section 8-42-104(5)(b), documentation shall be attached to the admission establishing prior impairment to the same body part that was identified, treated and independently disabling at the time of the work-related injury.

5-6 TIMELY PAYMENT OF COMPENSATION BENEFITS

- (A) Benefits awarded by order are due on the date of the order. After all appeals have been exhausted or in cases where there have been no appeals, insurers shall pay benefits within thirty days of when the benefits are due. Any ongoing benefits shall be paid consistent with statute and rule.
- (B) Temporary disability benefits awarded by admission are due on the date of the admission and the initial payment shall be paid so that the claimant receives the benefits not later than 5 calendar days after the date of the admission. Temporary total disability benefits are payable at least once every two weeks thereafter. In some instances an Employer's First Report of Injury and admission can be timely filed, but the first installment of

compensation benefits will be paid more than 20 days after the insurer has notice or knowledge of the injury. So long as the filings are timely and benefits timely paid and for the entire period owed as of the date of the admission, the insurer will be considered in compliance.

- (C) Permanent disability benefits awarded by admission are retroactive to the date of maximum medical improvement and shall be paid so that the claimant receives the benefits not later than 5 calendar days after the date of the admission. Subsequent permanent disability benefits shall be paid at least once every two weeks.
- (D) An insurer shall receive credit against permanent disability benefits for any temporary disability benefits paid beyond the date of maximum medical improvement.

5-7 PERMANENT PARTIAL DISABILITY BENEFIT RATES

- (A) Permanent partial disability benefits paid as compensation for a non-scheduled injury or illness which occurred on or after July 1, 1991, shall be paid at the temporary total disability rate, but not less than one hundred fifty dollars per week and not more than fifty percent of the state average weekly wage at the time of the injury.
- (B) Scheduled impairment benefits shall be paid at the calculated rate pursuant to [§ 8-42-107 \(6\) C.R.S.](#)
- (C) Where scheduled and non-scheduled injuries occurred resulting in impairment, the impairment benefits and the scheduled impairment benefit shall be paid concurrently.

5-8 ADMISSION FOR PERMANENT TOTAL DISABILITY BENEFITS

- (A) An insurer shall file an admission of liability for permanent total disability benefits on a final admission of liability form prescribed by the Division.
- (B) An insurer may terminate permanent total disability benefits without a hearing by filing an admission of liability form with all of the following attachments:
 - (1) A death certificate or written notice advising of the death of a claimant;
 - (2) A receipt or other proof substantiating payment of compensation to the claimant through the date of death; and
 - (3) A statement by the insurer as to its liability for payment of:
 - (a) Death benefits and
 - (b) If there are dependents, the unpaid portion of permanent total disability benefits the claimant would have received had s/he lived until receiving compensation at the regular rate for a period of six years.

5-9 REVISING ADMISSIONS

- (A) Within the time limits for objecting to the final admission of liability pursuant to [§ 8-43-203, C.R.S.](#), the Director may allow an insurer to amend the admission for permanency, by notifying the parties that an error exists due to a miscalculation, omission, OR clerical error.

- (B) The period for objecting to a final admission begins on the mailing date of the last final admission.
- (C) This subsection applies to claimants with an open claim with dates of injury on or after July 1, 1991 and before August 5, 1998 with the most recent and valid Final Admission of Liability filed before September 1, 1999 to which a timely objection was filed by the claimant but no Division independent medical examination was held before September 1, 1999. The carrier, self-insured employer, or non-insured employer may file an amended Final Admission of Liability providing notice to the claimant of the requirement to mail a notice and proposal to select an independent medical examiner per [§ 8-42-107.2 C.R.S.](#) Failure to provide such notice by amended Final Admission of Liability as indicated in this subsection shall preclude the carrier, self-insured employer or non-insured employer from asserting that the claimant failed to timely file a notice and proposal to select an independent medical examiner per [§ 8-42-107.2 C.R.S.](#) If the notice is provided by amended Final Admission of Liability the carrier, self-insured employer or non-insured employer is not precluded from subsequently raising any relevant equitable argument, such as waiver, laches or estoppel, regarding whether the notice and proposal was timely filed.

5-10 LUMP SUM PAYMENT OF AN AWARD

- (A) For lump sum requests less than or equal to \$10,000.00 for permanent partial disability awards for whole person or scheduled impairment, and where the injury or illness occurred on or after July 1, 1991, the following applies per [§ 8-42-107.2 C.R.S.](#):
 - (1) Lump sum payment of \$10,000.00, or the remainder of the award, if less, shall automatically be paid, less discount, on the claimant's written request to the insurer. The insurer shall calculate the sum certain and issue payment taking applicable offsets (i.e., disability benefits, incarceration, garnishments) within ten (10) business days from the date of mailing of the request by the claimant.
- (B) For lump sum requests greater than \$10,000.00 for permanent partial awards, or for any permanent total, or dependents' benefits, the following applies per [§ 8-43-406 C.R.S.](#):
 - (1) If the claimant is represented by counsel, a request for a lump sum payment of a portion or remaining benefits shall be made by submitting a Request for Lump Sum Payment form to the insurer and the Division, if the claimant has indicated that the admission will be accepted as filed, relative to permanent partial disability and maximum medical improvement. The claimant is not required to waive the right to pursue permanent total disability benefits as a condition to receiving the lump sum. Within ten (10) business days of the date the Request for Lump Sum Payment form was mailed, the insurer shall issue the payment and file the required benefit payment information with the Division, the claimant and the claimant's attorney.
 - (a) The insurer shall have ten (10) business days from the claimant's request to object to the payment of the lump sum. Prior to payment and within the same ten (10) day time period, the insurer shall submit the lump sum calculations to claimant, claimant's attorney and the Division providing the reason for the objection. Upon receipt of the form the Director shall make a determination on the lump sum request.
 - (b) The claimant shall have ten (10) business days from the date the payment or payment information was mailed to object to the accuracy of the payment by stating the basis for the objection, in writing, to the

Division and insurer. Following receipt of the objection, the Director shall make a determination on the lump sum payment.

- (c) The total of all lump sums may not exceed \$60,000 per claim.
- (2) If the claimant is not represented by counsel, a request for a lump sum payment of benefits shall be made by submitting a Request for Lump Sum Payment to the insurer and the Division if the claimant has indicated that the admission will be accepted as filed, relative to permanent partial disability and maximum medical improvement. The claimant is not required to waive the right to pursue permanent total disability benefits as a condition to receiving the lump sum. Within ten (10) business days of the date the Request for Lump Sum Payment form was mailed, the insurer shall file the required lump sum calculation information with the Division and the claimant.
 - (a) The claimant shall have ten (10) business days from the date of mailing of the benefit payment information provided by the insurer to object to the accuracy of this information. In the absence of an objection, a lump sum order issued by the Director will be based upon the information submitted.
 - (b) The total of all lump sums may not exceed \$60,000 per claim.
- (C) The insurer shall issue payment within ten (10) business days of the date of mailing of the order by the Director.

5-11 COMPUTATION OF BENEFITS

The workers' compensation benefit amount is based upon a seven day calendar week.

5-12 RECEIPTS

Upon demand of the Director, an insurer shall produce to the Division a receipt, canceled check, or other proof substantiating payment of compensation to the claimant or medical reimbursement to a provider or claimant.

5-13 INFORMATION ON CLAIMS ADJUSTING

Every insurer, or its designated claims adjusting administrator; shall provide the following information on claims adjusting practices to the Division:

- (A) The name, address and telephone number of the administrator(s) responsible for its claims adjusting. This information shall be provided upon request or within 30 days of any change in the administrator(s) or the geographical location of the administrator(s). Notice of such change shall be provided in writing to both the claimant and the Division. Notice shall include the name, address, and toll-free telephone number of the claims administrator(s).
- (B) A list of all claims established with the Division that are affected by the change described in the preceding paragraph. The list shall include claimant name, social security number, date of injury, insurer's claim number, and worker's compensation claim number, if available.
- (C) Upon request of the Director, any or all records, including any insurer administrative policies or procedures, pertaining to the adjusting of Colorado Workers' Compensation

claims. This authority shall not extend to personnel records of claims personnel. All documents shall remain confidential.

5-14

SURVEYS

- (A) Within 30 days following closure of each claim that was reported to the Division, the insurer shall survey the claimant. If the claimant is deceased the survey shall be presented to the claimant's dependents, if there are such dependents. If two or more claims have been merged or consolidated, one survey may be presented.
- (B) If the claimant has previously authorized the insurer to communicate through electronic transmission, the survey may be sent to the claimant electronically. Otherwise, the survey shall be mailed to the claimant. If mailed, along with the survey, the insurer shall provide a return postage pre-paid envelope for the claimant to use when returning the survey.
- (C) The survey shall include the name of the insurer. The survey shall also have a space for the claimant to sign if communicated by mail. The survey shall include the following language: "This survey relates to your recent workers' compensation claim. We would like to find out how satisfied you are with the way your claim was handled." The survey shall include instructions as to how to return the completed survey to the insurer, and the sentence "Insurers and employers are prohibited by law from taking any disciplinary action or otherwise retaliating against those who respond to this survey." In addition, the survey shall set forth only the following questions:
- (1) On a scale from 1 to 5, with 1 being the least satisfied and 5 being the most satisfied, please describe your satisfaction with the level of courtesy shown to you in relation to your workers' compensation claim.
1 2 3 4 5
 - (2) On a scale from 1 to 5, with 1 being the least satisfied and 5 being the most satisfied, please describe your satisfaction with how promptly you received medical care.
1 2 3 4 5
 - (3) On a scale from 1 to 5, with 1 being the least satisfied and 5 being the most satisfied, please describe your satisfaction with how promptly your claim was handled.
1 2 3 4 5
 - (4) On a scale from 1 to 5, with 1 being the least satisfied and 5 being the most satisfied, please describe your satisfaction with how quickly any disputes in your claim were resolved. If you did not have any disputes, please mark NA.
1 2 3 4 5 NA
 - (5) On a scale from 1 to 5, with 1 being the least satisfied and 5 being the most satisfied, please describe your overall satisfaction with the way your claim was handled.

(6) The name of the adjuster handling your claim, if known.

(D) On or before the last day of January, 2011, and on or before the last day of January in each following year, the insurer shall report the survey results to the Division. The report shall include the total number of surveys presented to claimants during the preceding calendar year, but shall be based on all survey results actually received by the insurer during that time. For the questions set out in (C)(1), (C)(2), (C)(3) and (C)(5) above, the insurer shall report the number of responses to the question and the average score based on those responses. For question (C)(4), the insurer shall report the number of responses to the question, the number of responses that indicated NA, and the average of those responses that provided a numerical response. There shall be only one report per insurer per year. The insurer shall maintain the actual survey responses for a minimum of six months after providing the results to the Division, and shall provide the survey results to the Division upon request.