RULE IV

CLAIMS ADJUSTING REQUIREMENTS

A. Filing of Employer's First Report of Injury

1. An employer shall report a work-related injury or illness on the employer's first report of injury form prescribed by the Division. The employer shall transmit the employer's first report of injury form to its insurance carrier within the 10-day period specified by Statute.

2. Whenever an Employer's First Report of Injury or Worker's Claim for Compensation form is filed with the Division and assigned a workers= compensation claim number, the carrier shall state whether liability is admitted or contested within 20 days after notice or knowledge of the injury pursuant to statute.

3. Written report of injury by any employee of the employer shall constitute sufficient notice by the claimant.

B. Initial Notice to Claimant

At the time an in or out-of-state insurance carrier notifies the Division of its position on a claim, the insurance carrier shall notify the claimant in writing of the carrier'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.

C. Employer's Supplemental Report

Upon an employee's return to work, an employer's supplemental report shall be filed by the insurance carrier on the form prescribed by the Division.

D. Filing of Medical Reports

1. Medical reports shall not be filed with the Division except under the following circumstances:

   a. When attached to an admission of liability form, or a petition to suspend benefits, or

   b. 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

c. When otherwise required by any other rule or the Act, or

d. At the request of the director.

E. Timely Payment of Compensation Benefits

1. Benefits awarded by order are due on the date of the order, except when a petition to review the order is filed or a request for specific findings of fact is filed. In such case benefits for those issues under review are due on the date the order becomes final.

2. Temporary disability benefits awarded by admission are due on the date of the admission and payable once every two weeks thereafter.

3. Permanent disability benefits awarded by admission are due on the date of the admission.

4. For all admissions dated on or after January 1, 1993, permanent disability benefits shall be paid every two weeks.

F. Permanent Partial Disability Benefit Rate

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.

G. Final Payment of Compensation

1. Whenever an insurance carrier terminates temporary disability benefits pursuant to Rule IX on the grounds the claimant has reached maximum medical improvement, the admission of liability form shall contain an admission for permanent disability benefits, if any.

2. An insurance carrier shall receive credit against permanent disability benefits for any temporary disability benefits paid beyond the date of maximum medical improvement.
   a. Paragraph 2 of this section shall not apply in cases where vocational rehabilitation is offered, or

b. In claims based upon an injury or illness occurring prior to 7/2/87 at 4:16 p.m. where the claimant is ordered to undergo a vocational rehabilitation evaluation but has not commenced a vocational rehabilitation program or received a director's determination that the claimant is not eligible for vocational rehabilitation services.

3. Whenever a worker's compensation claim has been closed by final order of the director, administrative law judge, Industrial Claims Appeal Panel or court, the insurance carrier shall file a final payment notice within 30 days of the date of the final order.

H. Receipts

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

I. Certificates Of Mailing

Any document that is certified for mailing, including admissions, must be placed in the U.S. mail or delivered on the date of certification.

J. Information on Claims Adjusting

Every insurance carrier, or its designated claims adjusting administrator, in or out of state, shall provide the following information on claims adjusting practices to the Division:

1. 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).

2. 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, carrier claim number, and workers' compensation claim number, if available.

3. Upon request of the director, any or all records, including any insurance carrier 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.

K. Admission for Permanent Total Disability Benefits

1. An insurance carrier shall file an admission of liability for permanent total disability benefits on a final admission of liability form prescribed by the Division.

2. An insurance carrier may terminate permanent total disability benefits without a hearing by filing an admission of liability form with all of the following attachments:

a. A death certificate or written notice advising of the death of a claimant;

b. A receipt or other proof substantiating payment of compensation to the claimant through the date of death; and

c. A statement by the carrier as to its liability for payment of:

(1) Death benefits and

(2) 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.

L. Revising Admissions

1. Within the time limits for objecting to the final admission of liability pursuant to 8-43-203, the director may allow a carrier to amend the admission for permanency, by notifying the parties that an error exists due to a miscalculation, omission, clerical error, or misapplication of the statute.

2. The period for objecting to a final admission begins on the mailing date of the last final admission.

3. 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 C.R.S. section 8-42-107.2. 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 C.R.S. section 8-42-107.2. 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.

M. Filing of Vocational Rehabilitation Reports

1. All vocational rehabilitation forms and reports for claims based upon an injury occurring on or prior to July 2, 1987 at 4:16 p.m. shall be filed with the Division and all parties copied.

2. Vocational reports for claims based upon an injury on or after July 2, 1987 at 4:16 p.m. shall not be filed with the Division except when requested by the director, when attached to a final admission, or filed pursuant to Rule VIII I. If the claimant participates in a vocational evaluation, or if the carrier offers vocational services and the claimant accepts, written reports must be produced and a copy of every vocational report not filed with the Division shall be exchanged with all parties within 15 working days of receipt.

N. Admissions of Liability

1. When the final admission is predicated upon medical reports, such reports shall accompany the admission including any evaluation record (worksheets) associated with an impairment rating. The admission shall specify and describe the insurance carrier'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.

   a. For dates of injury on or after August 5, 1998, an objection form prescribed by the Division, shall accompany every final admission of

liability and shall precede any other attachment.

2. When an admission is filed for medical benefits only, the admission shall include remarks outlining the basis for denial of temporary and permanent disability benefits.

3. 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.

4. For all injuries required to be filed with the Division with dates of injury on or after July 1, 1991:

   a. Where the claimant is a state resident at the time of MMI:

      (1) 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 insurance carrier shall refer the claimant to a level II accredited physician within 40 days after the determination of MMI for a medical impairment rating.

      (2) 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.

   b. Where the claimant is not a state resident at the time of MMI:

      (1) 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 insurance carrier all test results and relevant medical information. Within 20 days of receipt of the medical information, the insurance carrier shall appoint a level II accredited physician to determine the claimant's medical

impairment rating from the information that was transmitted.

(2) 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 insurance carrier shall arrange and pay for the claimant to return to Colorado for examination, testing, and rating, at the expense of the insurance carrier. The insurance carrier 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.

5. For those injuries required to be filed with the Division with dates of injury on or after July 1, 1991, and subject to section 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 insurance carrier shall either:

a. File an admission of liability consistent with the physician's opinion, or

b. Request a Division Independent Medical Examination (IME) on the issue of medical impairment in accordance with Rule XIV L.3.

6. Within 30 days after the date of mailing of the IME's report determining medical impairment pursuant to Section 8-42-107(8), the insurance carrier shall either admit liability consistent with such report or file an application for hearing. This section does not pertain to IMEs rendered under Section 8-43-502.

7. The insurance carrier 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 Part 5 of this Rule IV N., or an order. Any such modifications shall not affect an earlier award or

admission as to monies previously paid.

8. For those injuries required to be filed with the Division with dates of injury on or after July 1, 1991, and subject to Section 8-42-107(2), scheduled injuries:

   a. The time requirements as set forth in part 4 of this Rule IV N. apply.

   b. 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 insurance carrier shall either:

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

      (2) Set the matter for hearing.

O. Compliance Review

1. Every insurance carrier shall submit to reviews of its claim files for injuries arising on or after July 1, 1991, by the Carrier Practices Unit, on behalf of the Division of Workers' Compensation. The Division shall conduct reviews for the purpose of ensuring that benefits are calculated accurately and paid timely and that claims are otherwise handled in accordance with the Workers' Compensation Act and these Rules of Procedure.

   a. The Division shall inform the insurance carrier of the review in writing and provide a list of files to be reviewed at least 15 calendar days prior to the commencement of the review.

   b. At the time of the review, and for each file listed, the insurance carrier shall make the file available or provide to the Division a copy of the following documents: all wage records and reports, all records of medical and compensation payments, all copies of paid medical billings, all medical reports, all vocational rehabilitation reports, all notices of contest, all admissions of liability, and all correspondence pertaining to that claim, excluding work product. If an insurance carrier elects an on-site audit and the audit requires that the reviewers travel out-of-state, said carrier shall cover travel costs necessitated by

and incidental to the review.

c. Failure to provide information as defined under 1.b. above shall be considered a violation of the claims management efforts of the Division as subject to section 8-43-218, C.R.S., and may subject the carrier to penalties pursuant to Rule XI G. and section 8-43-218(3), C.R.S. In the event sanctions are imposed pursuant to the above section, the carrier shall be provided remedies as set forth in section 8-43-207, C.R.S.

2. The insurance carrier shall establish dates of receipt by the carrier on all documents filed with the Division and on all medical bills and reports required to be exchanged among parties of interest. For those documents which are required to be exchanged by the insurance carrier, the carrier shall verify the date of mailing on the face of the document. For those claims filed prior to the effective date of this rule, if there is no date stamp, date of receipt may be presumed to occur three days after the date of the document or billing date. The carrier may establish its date of receipt of the Worker's Claim for Compensation by its date stamp in the first instance or by three days after the date of the transmittal letter from the Division.

3. The issues to be considered during the review shall include, but shall not be limited to, the following:

a. A comparison of the date of receipt of the Employer's First Report of Injury or Worker's Claim for Compensation form and the date of the admission or Notice of Contest pursuant to the provisions of section 8-43-203, C.R.S.

b. The calculation of average weekly wage as set forth in sections 8-40-201(19) and 8-42-102, C.R.S.; verification for the basis of the calculation may be required.

c. The calculation of compensation benefits pursuant to sections 8-42-105, 8-42-106, 8-42-107, and 8-42-111, C.R.S.

d. The date of each payment of compensation to ensure that benefits are paid timely and regularly, pursuant to section 8-42-105(2)(a), C.R.S. and Rule IV E.

e. A comparison of the medical billing date and the date of payment in

accordance with Rule XVI K.

f. Compliance with procedures for contesting liability for medical payments or for returning medical billings due to insufficient data in accordance with Rule XVI(K).

g. Modification, termination or suspension of benefits pursuant to section 8-42-105 and Rule IX.

h. Service of documents in accordance with Rule XI, and other applicable Rules of Procedure.

4. Reporting Process

a. The Division shall provide a report of the review findings to the carrier within 30 calendar days from the date the unit completes the review. The report shall contain the unit's findings and recommendations, identifying each claim for which a correction is indicated, if applicable.

b. The carrier shall have 30 calendar days from the date of the report to respond to or comply with the recommendations contained in the report, unless otherwise specified.

The response shall be mailed to the Director of the Division of Workers' Compensation. The carrier shall provide evidence of compliance by providing applicable documents such as amended admissions, supplemental reports, wage history, medical reports, etc.

c. The carrier or the Division may request a conference to discuss the review, within 30 days from the date of the report.

d. Nothing in this rule shall preclude the Division's ability to proceed under enforcement mechanisms provided by statute or rule.

e. Information, documentation and reports obtained from any individual, carrier representative, or any other person pursuant to the administration of this rule, in accordance with sections 8-47-202 and 8-47-203, C.R.S., except to the extent necessary for the proper administration of a claim for workers' compensation, shall be held confidential and shall not be published or be open to public

inspection in any manner, other than to public employees in the performance of their public duties or to an agent of the Division of Workers' Compensation designated as such in writing for the purpose of accomplishing the Division's functions under this rule.