DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation

WORKERS' COMPENSATION RULES OF PROCEDURE

7 CCR 1101-3 Rules 1 - 17 (Rule 17 exhibits published separately)

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

Rule 1 General Definitions and General Provisions

1-1 THE FOLLOWING DEFINITIONS SHALL APPLY UNLESS OTHERWISE INDICATED IN THESE RULES

(A) "Act" means articles 40 through 47 of title 8 of the Colorado Revised Statutes.

(B) "Claimant" means an employee or dependent(s) of a deceased employee claiming entitlement to benefits under the Act. For the purpose of notification and pleadings, the term claimant shall include the claimant's legal representative.

(C) "Director" means the Director of the Division of Workers' Compensation.

(D) "Division" means the Division of Workers' Compensation in the Department of Labor and Employment.

(E) "Electronically recorded" means a recording made using tape recording, digital recording, or some other generally accepted medium.

(F) "Employee" means an individual who meets the definition of "employee" in the Act.

(G) "Employer" means anyone who meets the definition of "employer" in the Act.

(H) "Insurer" means every mutual company or association, every captive insurance company, and every other insurance carrier, including Pinnacol Assurance, providing workers' compensation insurance in Colorado and every employer authorized by the Executive Director of the Department of Labor and Employment to act as its own insurance carrier as well as any workers' compensation self-insurance pool authorized pursuant to statute.

(I) "Notice" means actual or constructive knowledge.

(J) "Service" means delivery via United States mail, hand delivery, facsimile or, with consent of the party upon whom the documents are being served, electronic mail.

1-2 COMPUTATION OF TIME/DATE OF FILING

(A) Unless a specific rule or statute states to the contrary, the date a document or pleading is filed is the date it is mailed or hand delivered to the Division of Workers' Compensation or the Office of Administrative Courts.

(B) In computing any period of time prescribed or allowed by these rules, the day of the act, event, or default from which the designated period of time begins to run shall not be included. Thereafter, every day shall be counted, including holidays, Saturdays or Sundays. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a legal holiday, in which event the period runs until the end of the next day which is not a Saturday, a Sunday, or a legal holiday. The "next day" is determined by continuing to count forward when the period is measured after an event and backward when measured before an event.

(C) As used in this rule, "business day" refers to any day other than a Saturday, Sunday or legal holiday.

1-3 NOTARIZATION OF AUTHORIZATION FOR RELEASE OF INFORMATION

The claimant's signature must be notarized on all releases filed with the Division of Workers' Compensation pursuant to §8-47-203(1)(e), C.R.S.

1-4 SERVICE OF DOCUMENTS

(A) Whenever a document is filed with the Division, a copy of the document shall be mailed to each party to the claim and attorney(s) of record, if any.

(B) Any document that is certified as mailed, including admissions, must be placed in the U.S. mail or delivered on the date of certification. Except where specifically permitted by the division, documents may not be filed with the division via e-mail.

(C) 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. If the claimant participates in a vocational evaluation, or if the insurer offers vocational services and the claimant accepts, written reports must be produced and should be produced within 30 days and a copy of every vocational report not filed with the Division shall be exchanged with all parties within 15 working days of receipt.

1-5 REQUESTS FOR ORDERS UNDER §8-47-203(2), C.R.S.

(A) Requests made to the Division of Workers' Compensation pursuant to §8-47-203(2), C.R.S., for copies or inspection of orders entered by the Director or an administrative law judge shall:

(1) be made in writing and addressed to the Director and,

(2) state the name of the requester and include the requester's mailing address and phone number; and,

(3) specifically identify the criteria for orders being requested. For example, all orders on the merits from a specific time period or all orders involving specified issues or injuries, etc.; and

(4) state the purpose for reviewing the orders.

(B) The requester shall provide any additional information required by the Division. After receiving such a request the Division will provide a cost estimate for processing the request. The requester may agree to pay the costs involved or decline further processing of the request. At the discretion of the Division payment may be required prior to the work being performed.

(C) To protect the confidentiality of the claimant and the employer named in the requested orders:

(1) requests shall not be accepted for orders based on claimant or employer names, or other uniquely identifying claimant or employer information; and,

(2) requests shall not be accepted for any criteria resulting in the inclusion of fewer than three claimants or employers in the group of orders inspected, unless approved by the Director or the Director's designee.

1-6 MEDIATION

Parties to a dispute may consent to submit any dispute to mediation pursuant to the provisions of §8-43-205, C.R.S. Requests for mediation should be filed with the Division of Workers' Compensation

1-7 EMPLOYER CREDIT FOR WAGES PAID UNDER §8-42-124(2), C.R.S.

(A) An employer who wishes to pay salary or wages in lieu of temporary disability benefits may apply to the Director for authorization to proceed pursuant to §8-42-124(2), C.R.S.

(B) The application to the Director shall contain the following information:

(1) a reference to the contract, agreement, policy, rule or other plan under which the employer wishes to pay salary or wages in excess of the temporary disability benefits required by the act, and

(2) a description of the employees covered by the application and a statement that these employees will not be charged with earned vacation leave, sick leave, or other similar benefits during the period the employer is seeking a credit or reimbursement.

(C) An employer who has received approval from the Director to proceed under §8-42-124(2), C.R.S., shall indicate on the employer's first report of injury form whether the claim is subject to §8-42-124, C.R.S.

Rule 2 Workers' Compensation Insurance Premium And Payroll Surcharges

2-1 SURCHARGE REQUIREMENTS FOR INSURANCE CARRIERS

Pursuant to § 8-44-112(1), insurance carriers must file semiannual surcharge returns based upon the premium amounts for the periods July 1 through December 31 of each year and January 1 through June 30 of each year.

(A) Insurance carriers must use either Division Form WC 113 or the online surcharge application to file semiannual surcharge returns.

(B) The surcharge return must state the amount of premiums written for Colorado workers' compensation insurance, including any policy expense constants, membership fees, finance and service, or other administrative fees charged to the policyholders with the issuance or renewal of policies during the semiannual period covered by such return. These premiums are the same as the premiums reported to the Colorado Division of Insurance (DOI) in accordance with § 10-3-208, and regulations promulgated thereunder.

(C) Insurance carriers must verify the surcharge return by affidavits of at least two chief officers or agents, such as president and secretary.

(D) For the semiannual assessment period July 1 through December 31, carriers must file verifications and pay no later than the following January 31. For the semiannual assessment period January 1 through June 30, carriers must file verifications and pay no later than the following July 31.

(E) Insurance carriers may take a credit for actually refunded premiums as an offset against surcharges due within one year of the date the premium was refunded. The insurance carrier may not offset a credit of one subsidiary against the surcharge owed by another subsidiary.

2-2 SURCHARGE REQUIREMENTS FOR SELF-INSURED EMPLOYERS

Pursuant to § 8-44-112(3) every self-insured employer must report its semiannual payroll to the Division utilizing the division's online surcharge application.

(A) The filing must include the National Council on Compensation Insurance (NCCI) class codes, job titles and payroll for each employee, as instructed by the online surcharge application. The Division may request further information to verify the reported payroll data. The failure to report payroll timely or accurately may result in the computation of surcharge without the otherwise applicable discounts.

(B) Self-insured employer surcharges must be based on the manual premium, adjusted by Pinnacol Assurance discount applicable for the covered surcharge assessment period and modified by the experience rating factor as calculated by NCCI. No other rating factor shall be allowable. If the self-insured employer is unable to develop the experience rating factor, the employer may apply to the director for approval to use a 1.0 experience rating factor for the following surcharge rating period.

(C) Self-insured employers must provide a completed NCCI form setting forth all of the information and methodology used in the calculation of the experience modification using the Division's online surcharge application. For the semiannual assessment period July 1 through December 31, self-insured employers must report payroll and pay no later than January 31. For the semiannual assessment period January 1 through June 30, self-insured employers must report payroll and pay no later than July 31.

(D) All filings must be accompanied by an affidavit from a representative of the self-insured employer attesting to the accuracy of the included information.

(E) The division may audit any self-insured employer for purposes of ascertaining the correctness of the reported wage expenditure, number of persons employed, accuracy of information upon which the experience rating factor was calculated and such other information as may be necessary.

(F) If it is determined following an audit that the surcharge paid was incorrect as a result of inaccurate data or calculations submitted to the division, the director may by order retroactively adjust the surcharge to reflect accurate data or calculations.

2-3 SURCHARGE REQUIREMENTS FOR SELF-INSURANCE POOLS

Effective for the semiannual assessment period July 1, 2021 through December 31, 2021 and continuing thereafter, every self-insurance pool must report its semiannual payroll pursuant to §§ 8-44-112(3) -204 and -205, using Division Form WC 112.

(A) The filing must include the National Council on Compensation Insurance (NCCI) class codes, job titles, and individual payroll for each employee of each pool member, as well as aggregate total payroll for each class code in a spreadsheet format. The Division may request further information to verify the reported payroll data. The failure to report payroll timely or accurately may result in the computation of surcharge without the otherwise applicable discounts.

(B) Each self-insurance pool member must provide a completed NCCI form setting forth all of the information and methodology used in the calculation of the experience modification. The pool also must set forth the methodology used in calculating its weighted experience rating factor. If any pool member is unable to develop the experience rating factor, the pool may apply to the director for approval to use a 1.0 experience rating factor for that member for the following surcharge rating period.

(C) Self-insurance pool surcharges must be based on the manual premiums of each pool member, adjusted by Pinnacol Assurance discount applicable for the covered surcharge assessment period and modified by the pool's weighted experience rating factor. No other rating factor shall be allowable.

(D) For the semiannual assessment period July 1 through December 31, self-insurance pools must report payroll and pay no later than January 31. For the semiannual assessment period January 1 through June 30, pools must report payroll and pay no later than July 31.

(E) All filings must be accompanied by an affidavit from a representative of the self-insurance pool attesting to the accuracy of the included information.

(F) The Division may audit any self-insurance pool for purposes of ascertaining correctness of the reported wage expenditures, number of persons employed, accuracy of information and methodology upon which the experience rating factors were calculated, and such other information as may be necessary.

(G) If it is determined following an audit that the surcharge paid was incorrect as a result of inaccurate data or calculations submitted to the division, the director may by order retroactively adjust the surcharge to reflect accurate data or calculations.

2-4 SURCHARGE RATES

The following surcharge rates shall apply for the period beginning July 1 and continue indefinitely with periodic review by the director:

(A) The workers' compensation cash fund premium surcharge rate authorized by § 8-44-112(1)(a), shall be 1.40 percent of the amount of all premiums written as defined in section 2-1(b) or the premium equivalent amount established in section 2-2(b) of this rule.

(B) The additional assessment to fund the cost containment program authorized by § 8-44-112(1)(b)(i), shall be 0.03 percent of all premiums written, as defined in section 2-1(b). This assessment shall not be imposed on self-insured employers.

(C) The assessment to fund the subsequent injury fund authorized by §8-46-102(2)(a)(i), and the major medical fund authorized by § 8-46-202 shall be 0.0 percent of all premiums written as defined in section 2-1(b) or the premium equivalent amount established in section 2-2(b) of this rule.

Rule 3 Insurance Coverage

3-1 REPORTING REQUIREMENTS FOR INSURANCE CARRIERS AND EMPLOYERS

(A) The Division designates the National Council on Compensation Insurance, Inc. (NCCI) as its agent to receive, process, and make available to the Division, all the required notices. Insurance carriers shall transmit this data and all other data elements in the electronic format as directed by the Division through NCCI.

(B) Every insurance carrier shall advise the Division, by filing with NCCI, notice of the issuance or renewal of insurance coverage within thirty (30) calendar days of the effective date of coverage. The insurance carrier shall ensure that every policy reported to NCCI includes the correct federal employer identification number ("FEIN") or other taxpayer identification number(s) for each covered employer, employer's business operation, client company, and/or employing entity.

(C) Every insurance carrier shall advise the Division, by filing with NCCI, final notice of the cancellation of insurance coverage no later than thirty (30) calendar days after coverage is actually canceled. This subsection does not pertain to the preliminary notice of cancellation referenced in §8-44-110.

(D) Every employer shall provide on request to its insurance carrier all FEINs or other taxpayer identification number(s) for all the employer's business operations, client companies, and/or any other similar employing entities, in Colorado to which the insurance applies. All changes in FEIN or other taxpayer identification numbers shall be reported immediately to the insurance carrier. The insurance carrier shall report all changes in FEINs and taxpayer identification numbers to NCCI within thirty (30) calendar days of receipt.

(E) Every insurance carrier shall provide to the division all certificates of insurance requested by the division, unless the insurer denies coverage for the requested employer, employer's business operation, client company, and/or employing entity. Certificates issued to the division shall contain, at a minimum, the employer's name, employer's address, employer's FEIN or other taxpayer identification number, insurer's name, insurer's address, policy number, and effective dates of the policy. The insurer shall provide such certificate(s) or notify the division of the denial of coverage within five (5) days of the request.

(F) For purposes of the performance of the Director's responsibilities under §8-43-409, the prehearing conference and any hearing that the Director may determine necessary may be conducted by any competent person appointed by the Director or by any other person designated by the Director.

3-2 CARRIER REPRESENTATIVE

Every insurance carrier shall notify the Division's designated agent of the name, address and telephone number of its representative responsible for reporting coverage information. This information shall be provided within thirty (30) days upon request of either the Division or its agent, or within thirty (30) days of a change in the information.

3-3 SELF-INSURED EMPLOYERS

(A) Any pool authorized to self-insure shall advise the Division in writing of the effective date of self-insurance, the name and address of the pool administrator and the federal employer identification number of each covered member. This information shall be provided within thirty (30) days upon request of either the Division or its agent, or within thirty (30) days of a change in the information.

(B) All individual self-insurance permit holders shall advise the Division in writing of the federal employer identification number of the permit holder as well as of all covered subsidiaries. This information shall be provided within thirty (30) days upon request of either the Division or its agent, or within thirty (30) days of a change in the information.

3-4 Unreported/erroneous policies - insurance carriers

(A) Every insurance carrier who fails to comply with the reporting requirements of paragraphs (a) through (e) of rule 3-1 shall be subject to penalties.

(B) For certificates of workers' compensation insurance or other documentation that has been received by the division indicating policies that have not been reported by the insurer to NCCI or policies that contain errors in an employer's identifying information, a list of such policies will be generated by the division and provided to each insurer containing all unreported or inaccurate policies. The insurer shall have fifteen (15) days from the date the list is issued to report/correct each listed policy to NCCI, or provide to the division a written explanation of why the policy cannot be reported/corrected to NCCI.

(C) If, within fifteen (15) days following the issuance of the division's list of unreported or erroneous policies, the insurer fails to either report a listed policy to NCCI or provide a written explanation to the division of why the policy cannot be corrected or reported to NCCI, a deficiency notice and order to comply may be issued to the insurer for all outstanding unreported or erroneous policies. The insurer shall then have twenty (20) days from the date of issuance of the deficiency notice and order to comply to perform one of the following actions:

(1) Report a previously unreported policy to NCCI.

(2) File a corrected endorsement with NCCI in the event the policy information previously submitted to NCCI is incorrect.

(3) Provide a written explanation to the division of why the policy cannot be reported to or corrected with NCCI.

3-5 ELECTION TO REJECT COVERAGE

(A) An officer of a corporation or a member of a Limited Liability Company ("LLC") who elects to reject workers' compensation coverage shall complete and submit the division prescribed rejection of coverage form to the division if all the company's corporate officers and LLC members choose to reject coverage and the corporation or LLC has no employees other than the corporate officers or LLC members. If the corporation or LLC has workers' compensation insurance, the corporate officer(s) or LLC member(s) shall submit the division prescribed form or the insurance carrier's substantially equivalent form to the workers' compensation insurance carrier.

(B) The owner(s) of a sole proprietorship or partnership performing construction work who elect(s) to reject workers' compensation coverage shall complete and submit the division prescribed rejection of coverage form to the division if the sole proprietorship or partnership has no employees other than the owner(s). If the sole proprietorship or partnership has workers' compensation insurance, such owner(s) shall submit the division prescribed form or the insurance carrier's substantially equivalent form to the workers' compensation insurance carrier.

(C) The Notice of Election to Reject Coverage shall become effective the next business day following receipt of the notice by the insurance carrier or, if none, by the Division.

3-6 NOTICES TO EMPLOYEES

Every employer shall continuously post a notice to employees in one or more conspicuous places at all of the employer's work sites advising employees that the employer is insured for workers' compensation as required by law, identifying the name of the employer's insurance carrier or stating that the employer is self-insured. Such notice shall be on the division form WC 50. For non-self-insured employers, the required notice shall be supplied by the insurer.

3-7 FINES FOR DEFAULTING EMPLOYER

(A) Following the Director's determination that an employer has failed to obtain the required insurance or has failed to keep such insurance in force or has allowed the insurance to lapse or has failed to renew such insurance, the Director will impose fines on the defaulting employer and/or will compel the employer to cease and desist its business operations.

(B) For any period beginning three years prior to the date the employer is sent a notice to show compliance and where such employer has not previously been sent a notice to show compliance, the director shall impose a fine of five dollars ($5.00) per day for each day of the employer's default until the date of issuance of the notice to show compliance. If the employer's default continues after the issuance of the notice to show compliance, fines shall be issued in accordance with the following schedule until the employer complies with the requirements of the workers' compensation act regarding insurance or until further order of the director:

1-10 DAYS	$10/DAY
11-20 DAYS	$30/DAY
21-30 DAYS	$50/DAY
31-40 DAYS	$100/DAY
41+ DAYS	$250/DAY

(C) Where an employer provides the director with information related to its ability to pay the fine, the director may, if appropriate, modify the fine structure in rule 3-6(b).

(D) For the Director's finding of an employer's second and all subsequent defaults in its insurance obligations, daily fines from $250/day up to $500/day for each day of default will be until the employer complies with the requirements of the Workers' Compensation Act regarding insurance or until further order of the Director.

Rule 4 Carrier Compliance

4-1 CLAIMS COMPLIANCE AUDITS

(A) Every insurer shall submit to compliance audits of its claims. The purpose of compliance audits is to examine whether claims are adjusted in accordance with the Workers' Compensation Act and the Workers' Compensation Rules of Procedure.

(1) Identifying and underlying claim information examined as part of a compliance audit is accessible only to the insurer under review and shall not otherwise be open to any person except upon order of the Director. If the Director issues an order in a specific claim the order will be sent to all parties.

(2) Division personnel shall give advance written notice of the compliance audit to the insurer and provide an initial list of claims to be audited. Unless the Division determines that circumstances warrant otherwise, the insurer will be given at least 15 calendar days notice.

(3) The insurer shall make the claims selected for the compliance audit and any requested information, including training and procedure manuals, available to the auditor at the time and place designated by the auditor. If the audit requires out-of-state travel by the auditor, the insurer may be required to pay travel costs.

(4) Failure to make claims and/or information requested by the auditor available to the auditor for audit shall be considered willful refusal to comply with Division efforts.

(5) The insurer shall indicate the dates of its receipt on all documents it files with the Division as well as on all medical bills and reports. For those documents required to be exchanged, the insurer shall indicate on the face of the documents or by some other verifiable method, the date the documents were mailed or delivered and to whom they were mailed or delivered.

(B) A claim compliance level will be determined for each category examined during the audit. A compliance level is the ratio of deficiencies found within a category in relation to the total number of applicable audit inquiries reviewed in that category. A deficiency is a failure to comply with statute or rule. The categories to be examined during the claim compliance audit may include but are not limited to the following:

(1) Reporting of claims.

(2) Initial positions on liability.

(3) Timeliness of compensation payments.

(4) Accuracy of compensation payments.

(5) Medical benefit payments.

(6) Termination of temporary disability benefits.

(7) Final Admissions.

(8) Average Weekly Wage.

(9) Waiting period.

(10) Document exchange.

(C) Fines will be imposed for the repeated failure to demonstrate satisfactory compliance. A compliance level of 90% or higher in each category is considered satisfactory compliance. No fine will be imposed for deficiencies in any category in which satisfactory compliance is determined in the compliance audit. For the categories listed in subparagraphs 8 through 10 in paragraph (B) of this Rule 4-1, the auditor will comment upon the insurer's adjusting practices but fines will not be imposed for deficiencies found on compliance audits in those categories.

(D) After reviewing the insurer's procedures and examining the claims selected for audit and other information requested, the auditor will provide the insurer with preliminary audit findings, including compliance levels. Thereafter:

(1) The insurer will have thirty (30) calendar days within which to agree in writing with the preliminary audit findings. If the insurer does not agree with the preliminary audit findings it shall, within the same 30 calendar days, state with particularity and in writing to the auditor its reasons for all disagreements and provide in writing all relevant legal authority, and/or other relevant proof upon which it relies in support of its position(s) concerning its disagreements with the preliminary findings.

An extension of time not to exceed 30 additional days may be submitted in writing to the auditor prior to the expiration of the 30 calendar days afforded to the insurer to agree with the preliminary findings. Failure to timely submit a written disagreement will be considered waiver of the right to do so.

(2) A representative of the division and the insurer shall have twenty (20) calendar days after submission of the written disagreement with the preliminary audit findings within which to resolve those disagreements and to agree to the preliminary audit findings.

(3) If the representative of the division and the insurer are unable to agree on the preliminary findings within the 20-day period afforded in paragraph (D)(2) of this Rule 4-1, the preliminary audit findings along with the insurer's written disagreements will be referred to the Director for final determination regarding the audit findings. The final determination of the relevance and/or weight given to any authority or proof submitted in connection with the insurer's disagreements regarding audit findings is reserved to the Director.

(4) When a determination regarding audit findings has been made by the Director, a Final Audit Report and/or order will be issued.

(5) When the insurer has agreed to the preliminary audit findings without disagreement, or when the insurer fails to timely provide a written disagreement or when the Director has made a determination regarding audit findings as provided in paragraph (D) of this Rule 4-1, the Final Audit Report will issue. The Final Audit Report will contain a summary of the final audit findings, comments on the insurer's adjusting practices, and a determination of the insurer's compliance levels. Fines will be ordered as determined by the Director in accordance with Rule 4-2.

(6) Insurers may be required to correct deficiencies in all claims covered by the audit period if the compliance level for any identified category is below 90%. Insurers may also be required to undergo training if indicated by audit results or for such other reasons as may be determined by the Director.

4-2 fines for claims audits

(A) An insurer's first claims audit conducted after January 1, 2006 measures and establishes the insurer's levels of compliance with applicable statutes and rules in identified categories. A compliance level below 90% in any compliance category is considered unsatisfactory. A compliance level below 90% in a compliance category listed in subparagraphs 1 through 7 in paragraph (B) of Rule 4-1, on consecutive compliance audits is considered repeated non-compliance. Repeated non-compliance in any category set out in Rule 4-1(B)(1) through (7) shall result in the insurer being ordered to pay a fine.

(B) In order for an insurer's unsatisfactory performance to result in fines for failure to meet the 90% compliance standard in any category set out in Rule 4-1(B)(1) through (7), its compliance level in that category must be below 90% on at least two consecutive audits.

(C) Each category for which a fine may be imposed has a fine schedule. The amount of any fine will be determined in accordance with the findings in the Final Audit Report and in accordance with this Rule 4-2. Fines for repeated violations in any category set out in Rule 4-1(B)(1) through (7) are based on the compliance level for that category and as set out in this Rule 4-2.

(D) The dollar amount of a fine is arrived at by first locating the insurer's compliance level on the appropriate schedule found in paragraph (E) of this Rule 4-2. The number of identified deficiencies in the relevant category is multiplied by the "per deficiency" dollar amount for the appropriately numbered finable occurrence indicated in the schedule to arrive at a fine amount for that category.

(E) The fine schedule for each consecutive finable compliance category is as follows:

(1) For the categories listed in Rule 4-1(B) subparagraphs 1,5,7:

(a)	80-89%	$60
(b)	70-79%	$90
(c)	60-69%	$120
(d)	<60%	$150

(2) For the categories listed in Rule 4-1(B) subparagraphs 2,3,4,6:

(a)	80-89%	$100
(b)	70-79%	$200
(c)	60-69%	$400
(d)	<60%	$600

4-3 POLICY COMPLIANCE AUDIT

(A) Every insurer shall submit to compliance audits of its policy reporting. Policy information to be reviewed will consist of all new, renewal and cancellation policy data information that has already been reported to the Division. The purpose of compliance audits is to examine whether insurance coverage is reported in accordance with the Workers' Compensation Act and the Workers' Compensation Rules of Procedure.

(1) Identifying and underlying coverage information examined as part of a compliance audit is accessible only to the insurer under review and shall not otherwise be open to any person except upon order of the Director. If the Director issues an order for a specific policy the order will be sent to all parties.

(2) Division personnel shall give advance written notice of the compliance audit to the insurer setting forth the period to be audited. Unless the Division determines that circumstances warrant otherwise, the insurer will be given at least 15 calendar days notice.

(3) The insurer shall make any requested information related to the compliance audit available to the auditor at the time and place designated by the auditor.

(4) Failure to make information requested by the auditor available to the auditor for audit shall be considered willful refusal to comply with Division efforts.

(B) A compliance level will be determined for each category examined during the policy compliance audit. A compliance level is the ratio of deficiencies found within a category in relation to the total number of applicable audit inquiries reviewed in that category. A deficiency is a failure to comply with statute or rule. The categories to be examined during the compliance audit may include but are not limited to the following:

(1) Reporting of new or renewal policies

(2) Reporting of policy cancellations

(C) Fines will be imposed for the repeated failure to demonstrate satisfactory compliance. A compliance level of 95% or higher in each category is considered satisfactory compliance. No fine will be imposed for deficiencies in any category in which satisfactory compliance is determined in the compliance audit.

(D) After examining the relevant policy data for audit and other information requested, the auditor will provide the insurer with preliminary audit findings, including compliance levels. Thereafter:

(1) The insurer will have thirty (30) calendar days within which to agree in writing with the preliminary audit findings. If the insurer does not agree with the preliminary audit findings it shall, within the same 30 calendar days, state with particularity and in writing to the auditor its reasons for all disagreements and provide in writing all relevant legal authority, and/or other relevant proof upon which it relies in support of its position(s) concerning its disagreements with the preliminary findings.

An extension of time not to exceed 30 additional days may be submitted in writing to the auditor prior to the expiration of the 30 calendar days afforded to the insurer to agree with the preliminary findings. Failure to timely submit a written disagreement will be considered waiver of the right to do so.

(2) A representative of the Division and the insurer shall have twenty (20) calendar days after submission of the written disagreement with the preliminary audit findings within which to resolve those disagreements and to agree to the preliminary audit findings.

(3) If the representative of the Division and the insurer are unable to agree on the preliminary findings within the 20-day period afforded in paragraph (D)(2) of this Rule 4-3, the preliminary audit findings along with the insurer's written disagreements will be referred to the Director for final determination regarding the audit findings. The final determination of the relevance and/or weight given to any authority or proof submitted in connection with the insurer's disagreements regarding audit findings is reserved to the Director.

(4) When a determination regarding audit findings has been made by the Director, a Final Audit Report and/or order will be issued.

(5) When the insurer has agreed to the preliminary audit findings without disagreement, or when the insurer fails to timely provide a written disagreement, or when the Director has made a determination regarding audit findings as provided in paragraph (D) of this Rule 4-3, the Final Audit Report will issue. The Final Audit Report will contain a summary of the final audit findings, comments on the insurer's policy reporting practices, and a determination of the insurer's compliance levels. Fines will be ordered as determined by the Director in accordance with Rule 4-4.

(6) Insurers may be required to correct deficiencies in all policy information covered by the audit period if the compliance level for any identified category is below 95%. Insurers may also be required to undergo training if indicated by audit results or for such other reasons as may be determined by the Director.

4-4 FINES FOR POLICY AUDITS

For the categories listed in Rule 4-3(B) subparagraphs (1) and (2):

Fines per consecutive Audit Deficiency per Compliance Category

Compliance Level	Fine
90-94%	$60
85-89%	$90
80-84%	$120
<80%	$150

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 only as directed by the Division.

(C) All first reports of injury and notices of contest filed with the Division shall be transmitted electronically via 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) All filings shall be sent via electronic submission to the Division.

(a) Only one file per submission is permitted. All exhibits shall be combined into one file with the filing or form. Multiple attachments will not be accepted.

(b) The subject line of the email and the attached file name must be named in this order: wc#, claimant first and last name, and type of document.

(c) The certificate of service should reflect the date it was submitted to the division of workers' compensation.

(d) All admissions; petitions to modify, terminate, or suspend (wc54); request for lump sum payments (wc62); and motions to close for lack of prosecution (wc192) must be sent to: cdle_dowc_filings@state.co.us

(i) In order to electronically submit a motion to close, all parties must have an electronic mail address

(ii) If electronic mail addresses are not available, these forms will be accepted via regular mail along with self-addressed, postage-paid envelopes for all parties.

(e) All other motions (other than motions to close which are addressed under rule 7) and submissions for prehearings and settlement unit must be addressed to: cdle_dowc_prehearings@state.co.us. Motions must be accompanied by a proposed order.

(f) All other communications not specifically addressed in this rule, including but not limited to objections to final admissions, entries of appearance, and workers' claims for compensation must be addressed to: cdle_workers_compensation@state.co.us

(E) 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.

(F) In the event compliance with 5-1(C) is prevented by technological errors beyond the control of the filing party, a waiver may be requested by submitting the division-issued paper form along with a cover letter addressed to the Director identifying the reason for the request. Upon receipt of a request the Division will either accept the paper form or notify the filing party that electronic submission will be required.

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) If an injury results in a fatality, or three or more employees are injured in the same accident, a first report of injury shall be filed with the division within 3 days of notice to the insurance carrier or self-insured.

(2) A First Report of Injury must be filed within ten days of an employer receiving notice or knowledge of any of the following events:

(a) An injury or occupational disease has resulted in lost time from work for the injured employee in excess of three shifts or calendar days;

(b) The occurrence of a permanently physically impairing injury;

(c) For claims with dates of injury on and after August 10, 2022, when medical treatment supervised by an authorized treating physician and intended to cure or relieve the injury is provided for more than 180 days after the date of notice to the employer of the injury;

(d) An employee has contracted an occupational disease listed in any of the following categories:

(i) Chronic respiratory disease;

(ii) Cancer;

(iii) Pneumoconiosis, including but not limited to coal worker's lung, asbestosis, silicosis, and berylliosis;

(iv) Nervous system diseases;

(v) Blood borne infectious, contagious diseases.

(3) Within ten days after notice or knowledge of any claim for benefits, including medical treatment 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 may be filed until a workers' compensation claim number is assigned. A separate and distinct statement regarding liability is required for each claim in which a workers' compensation claim number is assigned.

(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, active medical treatment less than 180 days, or contraction of an occupational disease not listed in subsection (B) of this 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, a telephone number, and email address 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) business days of receipt. A claimant may opt to not receive copies of medical reports from the insurer under this section by providing written notice to the insurer. Such notice may be revoked by the claimant in writing at any time.

(B) For claims which are not required to be reported to the Division, the parties shall exchange medical reports within five (5) business days of a request for such information by a party to the claim.

(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 conditions(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 be presumed reasonable. Any request for information in excess of the presumption contained in this rule shall include a notice that the insurer is requesting information in excess of what is presumed reasonable and that providing the information is not required. If a party disputes that a request within the presumption 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. Requests for 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 an exchange of information under this Rule 5-4(D) is not considered discovery.

(E) Mental health records in the possession of an insurer or self-insured employer or any agent thereof shall not be exchanged with any party other than claimant or claimant's counsel unless necessary for medical evaluation, adjustment or adjudication of the claim or otherwise approved by the Director or an Administrative Law Judge.

An insurer may release mental health records concerning work restrictions to the employer but shall not disclose the actual mental health records to any third party unless necessary for medical evaluation, adjustment or adjudication of the claim or otherwise approved by the Director or an Administrative Law Judge.

5-5 ADMISSIONS OF LIABILITY

(A) When the final admission is predicated upon medical reports, a narrative report and appropriate worksheets MUST accompany the admission. The attachment of the physician's report of workers' compensation injury form is required in cases where such document is supplied by the physician concurrently with the narrative report. Attached documentation must provide a statement from an authorized treating physician regarding the date of maximum medical improvement, permanent impairment, and maintenance medical benefits.

(1) The physician's report of workers' compensation injury form or narrative report shall reflect the recommendation of the physician completing the form with regard to the provision of medical benefits after maximum medical improvement, as may be reasonable and necessary within the meaning of the act. The admission shall state the insurer's position on the provision of medical benefits after maximum medical improvement. If maintenance medical benefits are being denied, the admission shall make specific reference to the medical report by listing the physician's name and the date of the report in the remarks section of the admission.

(2) The objection form prescribed by the Division as part of the final admission form shall precede any attachment.

(3) For claims reported to the Division in which only medical benefits have been paid and no permanent impairment has been assigned, either the narrative report or the physician's report of workers' compensation injury form shall be attached as support.

(4) For claims reported to the Division in which only medical benefits have been paid and no permanent impairment has been assigned, a narrative report completed after the final admission of liability has been filed must be exchanged within fifteen (15) days of receipt.

(B) An admission filed for medical benefits only shall state the basis for denial of temporary and permanent disability benefits within the remarks section of the admission.

(C) Upon termination or reduction in the amount of compensation, a new admission shall be filed with supporting documentation on or prior to the next scheduled date of payment, regardless of the reason for the termination or reduction. An admission shall be filed within 30 days of any resumption or increase of benefits.

(1) Following any order (except for orders which only involve disfigurement) becoming final which alters or awards benefits, an admission consistent with the order shall be timely filed.

(2) The filing of an admission consistent with this section shall not be construed as a reopening of any issues closed by a prior admission or resolved by order.

(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:

(1) Within 30 days after the date of mailing or delivery of a determination of 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:

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

(b) Request a Division Independent Medical Examination (**D**IME) in accordance with Rule 11-3 and §8-42-107.2, C.R.S.,

(c) In cases involving only a scheduled impairment, an application for hearing or final admission may be filed without a Division Independent Medical Examination.

i) the filing of an application for hearing by the insurer under this provision shall not prevent the claimant from seeking a Division Independent Medical Exam on the issues of MMI and/or conversion to whole person impairment. The claimant shall have thirty (30) days from the filing of the application for hearing to request an independent medical exam.

ii) at the time the insurer files an application for hearing under this provision it shall concurrently provide a notification to the claimant that the claimant may request a DIME on the issues of MMI and/or conversion to whole person impairment, as well as a copy of the Division's notice and proposal form.

(F) Within 20 days after the date of mailing of the Division's notice of receipt of the Division Independent Medical Examiner's report, 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 Division Independent Medical Exam, a Division Independent Medical Examiner 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) 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:

(I) An admission of liability which includes a reduction in benefits for a safety rule violation must include a statement from a representative of the employer of the specific facts on which the reduction is asserted. The statement shall be attached as a separate document to the initial admission.

5-6 TIMELY PAYMENT OF COMPENSATION BENEFITS

(A) Benefits and penalties awarded by order are due three (3) business days after the order becomes final. Any ongoing benefits shall be paid consistent with statute and rule.

(B) Initial payment of temporary disability benefits awarded by admission shall be paid no later than the date the admission awarding benefits is filed and are considered due three (3) business days after the date of the admission. Temporary disability benefits are due at least once every two weeks thereafter from the date of the admission. Payment mailed via the United States Postal Service will be considered timely if postmarked at least three (3) business days prior to the due date and must include all benefits owed through the due date. 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. Provided the filings are timely and that benefits are timely paid for the entire period owed as of the date of the admission, the insurer will be considered in compliance

(C) Permanent impairment 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 three (3) business days after the date of the admission. Subsequent permanent disability benefits are due at least once every two weeks from the date of the admission. When benefits are continuing, the payment shall include all benefits which are due. Payment mailed via the United States Postal Service will be considered timely if postmarked at least three (3) business days prior to the due date.

(D) An insurer shall receive credit against permanent disability benefits for any temporary disability benefits paid beyond the date of maximum medical improvement.

(E) Benefits shall be calculated based on a seven (7) day calendar week.

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.

(1) For injuries resulting in a scheduled impairment, the permanent partial disability amount must be determined utilizing the scheduled rating calculation if it is higher than the nonscheduled rating calculation.

(C) Where scheduled and non-scheduled injuries occurred resulting in impairment, the scheduled and non-scheduled impairment benefits 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; and

(2) A statement by the insurer as to its liability for payment of:

(a) Death benefits and

(b) If there are dependents, the unpaid portion, if any, 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 FINAL 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.

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 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, 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) 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 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. Claimant shall have ten days from the insurer's objection to file a response. Upon receipt of the form the Director shall make a determination on the lump sum request.

(b) The claimant shall have ten 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. Insurer shall have ten days from the claimant's objection to file a response. Following receipt of the objection, the Director shall make a determination on the lump sum payment.

(c) The total of all lump sums issued per claim may not exceed the amount set forth in the Director's annual maximum benefit order in effect on the date the first non-$10,000 lump sum is requested.

(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) 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) 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 issued per claim may not exceed the amount set forth in the director's annual maximum benefit order in effect on the date the first non-$10,000 lump sum is requested.

(C) For lump sum requests greater than $10,000.00 for dependents' benefits, the following applies per § 8-43-406 C.R.S.:

(1) 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. Within ten (10) 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 insurer shall have ten (10) 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. Claimant shall have ten (10) days from the insurer's objection to file a response. Upon receipt of the form the Director shall make a determination on the lump sum request.

(b) The claimant shall have ten (10) 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. The insurer shall have ten (10) days from the claimant's objection to file a response. Following receipt of the objection, the Director shall make a determination on the lump sum payment.

(c) The total of all lump sums issued to all dependents may not exceed the amount set forth in the Director's annual maximum benefit order in effect on the date the first non-$10,000 lump sum is requested.

(i) When the weekly benefit amounts were previously determined by an Administrative Law Judge or the Director, a dependent's individual maximum lump sum amount shall be equivalent to the percent of total benefits as ordered.

(ii) When the weekly benefit amounts were not previously determined by an Administrative Law Judge or the Director, a dependent's individual maximum lump sum amount shall be determined by the Director.

(D) The insurer shall issue payment within ten (10) days of the date of mailing of the order by the Director.

5-11 DOCUMENTATION OF APPORTIONMENT

(1) For all 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 any prior injury, whether work-related or non work-related.

(2) If a permanent impairment rating is reduced on an admission based on a prior work-related injury 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 based on non-work-related injury, 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.

5-12 RECEIPTS

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

5-13 INFORMATION ON CLAIMS ADJUSTING

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

(1) The name, address**,** telephone number and e-mail address of the administrator(s) responsible for its claims adjusting.

(2) Within 30 days of any change in administrator(s) responsible for claims adjusting, the insurer or self-insured employer shall complete a "notice of change of carrier or adjusting firm" on the Division provided form.

(3) 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.

(B) Within 30 days of any change in the administrator(s), notice of such change shall be provided in writing to the claimant. Notice shall include the name, address, a telephone number, and email address of the claims administrator(s).

5-13 CORRESPONDENCE FROM THE DIVISION

(A) Every insurer and self-insured employer shall provide a mailing address for the receipt of communication from the Division. All correspondence from the Division regarding the claim will be sent to the address provided by the insurer or self-insured employer. Mailing to the address provided is deemed good service.

(B) An insurer or self-insured employer may designate a third party administrator (TPA) to handle specific claims by noting the designation on the first report of injury or an admission of liability. No correspondence will be sent to the TPA unless such a designation is made.

(1) In claims initiated by a workers' claim for compensation, the Division will forward the claim to the insurer or self-insured employer with a request for a position statement. The insurer or self-insured employer shall be responsible for forwarding the claim to the third party administrator (if any).

(2) The insurer or self-insured employer remains responsible for ensuring compliance with these rules of procedure as well as the workers' compensation act regardless of any designation of a third party administrator.

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 prepaid 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

(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.

1 2 3 4 5

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

(D) On or before the last day of January in each 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.

Rule 6 Modification, Termination or Suspension of Temporary Disability Benefits

6-1 TERMINATION OF TEMPORARY DISABILITY BENEFITS IN CLAIMS ARISING FROM INJURIES ON OR AFTER JULY 1, 1991

(A) In all claims based upon an injury or disease occurring on or after July 1, 1991, an insurer may terminate temporary disability benefits without a hearing by filing an admission of liability form with:

(1) a medical report from an authorized treating physician stating the claimant has reached maximum medical improvement; provided such admission of liability states a position on permanent disability benefits. This paragraph shall not apply in cases where vocational rehabilitation has been offered and accepted, or

(2) a medical report from the authorized treating physician who has provided the primary care, stating the claimant is able to return to full or regular duty, or

(3) a written statement from an employer or the claimant stating the claimant has returned to work at full wages and hours or setting forth the wages paid for the work to which the claimant has returned provided such admission of liability admits for temporary partial disability benefits, if the claimant has not returned to work at full wages, or

(4) A copy of a written offer delivered to the claimant with a signed certificate of service, containing both an offer of modified employment, setting forth duties, wages and hours and a statement from an authorized treating physician that the employment offered is within the claimant's physical restrictions.

(a) A written offer of modified duty may only be used to terminate benefits pursuant to this subsection if:

(i) A copy of the written inquiry to the treating physician is provided to the claimant by the insurer or EMPLOYER at the time the authorized treating physician is asked to provide a statement on the claimant's capacity to perform the offered modified duty; and

(ii) The claimant is provided a period of 3 business days from the date of receipt of the offer to return to work in response to the offer of modified duty.

(5) a copy of a certified letter to the claimant or a copy of a written notice delivered to the claimant with a signed certificate of service, advising that temporary disability benefits will be suspended for failure to appear at a rescheduled medical appointment with an authorized treating physician, and a statement from the authorized treating physician documenting the claimant's failure to appear, OR

(6) a letter or death certificate advising of the death of the claimant with a statement by the insurer as to its liability for death benefits.

6-2 TERMINATION OF TEMPORARY DISABILITY BENEFITS BY AN ADMISSION OF LIABILITY IN CLAIMS ARISING AFTER JULY 2, 1987 AT 4:16 P.M. AND BEFORE JULY 1, 1991

(A) In all claims based upon an injury or disease which occurred after July 2, 1987, at 4:16 p.m., an insurer may terminate disability benefits without a hearing by filing an admission of liability form with:

(1) a medical report from the authorized treating physician who has provided the primary care stating the claimant has reached maximum medical improvement; provided such admission of liability states a position on permanent disability benefits. This paragraph shall not apply in cases where vocational rehabilitation has been offered and accepted, or

(2) a medical report from the authorized treating physician who has provided the primary care stating the claimant is able to return to regular employment provided such admission of liability states a position on permanent partial disability benefits, or

(3) a written report from the employer or the claimant stating the claimant has returned to work and setting forth the wages paid for the work to which the claimant has returned; provided such admission of liability admits for temporary partial disability benefits, if any, or

(4) a letter or death certificate advising of the death of the claimant with a statement by the insurer as to its liability for death benefits.

6-3 TERMINATION OF TEMPORARY DISABILITY BENEFITS BY AN ADMISSION OF LIABILITY IN CLAIMS ARISING PRIOR TO JULY 2, 1987, AT 4:16 P.M.

(A) In all claims based upon an injury or disease which occurred prior to July 2, 1987, at 4:16 p.m., an insurer may terminate temporary disability benefits without a hearing by filing an admission of liability form with:

(1) a report from the authorized treating physician who has provided the primary care stating the claimant has reached maximum medical improvement and is released to return to an occupation which the claimant regularly performed at the time of the injury, or

(2) a report from the authorized treating physician who has provided the primary care stating the claimant has reached maximum medical improvement and a Director's determination that the claimant is not eligible for vocational rehabilitation services, or

(3) a written report from the employer or the claimant stating the claimant has returned to work and setting forth the wages paid for the work to which the claimant has returned; provided such admission admits for temporary partial disability benefits, if any, or

(4) a letter or death certificate advising of the death of the claimant with a statement by the insurer as to its liability for death benefits, OR

(5) a report from the authorized treating physician who has provided the primary care stating the claimant has reached maximum medical improvement and documentation the claimant has completed an approved vocational rehabilitation plan.

6-4 SUSPENSION, MODIFICATION OR TERMINATION OF TEMPORARY DISABILITY BENEFITS BY A PETITION

(A) When an insurer seeks to suspend, modify or terminate temporary disability benefits pursuant to a provision of the Act, and Rules 6-1, 6-2, 6-3, 6-5, 6-6, 6-7 or 6-9 are not applicable, the insurer may file a petition to suspend, modify or terminate temporary disability benefits on a form prescribed by the Division. All documentation upon which the petition is based shall be attached to the petition. The petition shall indicate the type, amount and time period of compensation for which the petition has been filed and shall set forth the facts and law upon which the petitioner relies.

(B) When an insurer seeks to retroactively decrease temporary benefits after the first indemnity admission of liability is filed. The petition must be filed within thirty (30) days of the initial indemnity admission. This section shall not be used to retroactively claim a safety rule violation.

(C) A copy of a response form prescribed by the Division shall be included with a copy of the petition to the claimant and claimant's attorney and the Division. Certification of this mailing shall be filed with the petition.

(D) If the claimant does not file a written objection with the Division within twenty (20) days of the date of mailing of the petition and response form, the Director may grant the insurer's request to suspend, modify or terminate disability benefits as of the date of the petition.

(E) When a claimant files a timely objection to a petition, the insurer shall continue temporary disability benefits at the previously admitted rate until an application for hearing is filed with the Office of Administrative Courts, and the matter is resolved by order. The Director finds that good cause exists to expedite a hearing to be held within sixty (60) days from the date of the setting, because overpayment of benefits may result if the suspension, modification or termination is granted.

(F) When a hearing is continued at the request of the claimant, the prehearing administrative law judge shall temporarily grant the relief requested in the petition, pending the continued hearing, if the reports and evidence attached to the petition and objection indicate a reasonable probability of success by the insurer. The continued hearing shall be held no later than thirty (30) days from the date of the request for continuance.

(G) When a hearing is continued at the request of the insurer, temporary disability benefits shall continue until the matter is resolved by order after the hearing.

6-5 MODIFICATION OF TEMPORARY DISABILITY BENEFITS PURSUANT TO STATUTORY OFFSET

An insurer may modify temporary disability benefits to offset social security, disability pension or similar benefits pursuant to statute by filing an admission of liability form with the Division, with documentation which substantiates the offset and figures showing how the amount of the offset was calculated pursuant to statute.

6-6 TERMINATION OR MODIFICATION OF TEMPORARY DISABILITY BENEFITS DUE TO CONFINEMENT

An insurer may terminate or modify temporary disability benefits pursuant to statute, by filing an admission of liability form with the Division with a document issued by a court of criminal jurisdiction, which establishes that the claimant is confined in a jail, prison, or any department of corrections facility as a result of a criminal conviction.

6-7 TERMINATION OF TEMPORARY DISABILITY BENEFITS PURSUANT TO THIRD-PARTY SETTLEMENT

An insurer may terminate temporary disability benefits pursuant to statute, by filing an admission of liability form with the Division with a copy of a document substantiating the claimant received money damages from a third-party claim arising from the worker's compensation injury and the amount of the award that may be offset pursuant to § 8-41-203, C.R.S.

6-8 FAILURE TO COMPLY WITH REQUIREMENTS OF RULE 6

(A) Temporary disability benefits may not be suspended, modified or terminated except pursuant to the provisions of this rule**;** pursuant to an order from the Director or pursuant to an order of the Office of Administrative Courts.

(B) If the Director concludes the insurer has not met the applicable requirements of this rule, the Director may order the insurer to continue payment of temporary disability benefits, pursuant to § §8-42-105(3) and 8-42-106(2), C.R.S., until the requirements of this rule are followed or until a hearing is held and further order entered.

6-9 TERMINATION OF TEMPORARY DISABILITY BENEFITS DUE TO FAILURE TO RESPOND TO AN OFFER OF MODIFIED EMPLOYMENT FROM A TEMPORARY HELP CONTRACTING FIRM IN CLAIMS FOR INJURIES OCCURRING ON OR AFTER JULY 1, 1996

(A) An insurer may terminate temporary disability benefits by filing an admission of liability with:

(1) a copy of the initial written offer of modified employment provided to the claimant, which clearly states that future offers of employment need not be in writing, a description of the policy of the temporary help contracting firm regarding how and when employees are expected to learn of such future offers, and a statement that benefits shall be terminated if an employee fails to timely respond to an offer of modified employment;

(2) a written statement from the employer representative giving the date, time, and method of notification which forms the basis for the termination of temporary disability benefits; and

(3) a statement from the attending physician that the employment offered is within the claimant's restrictions.

(B) The claimant is allowed a period of at least twenty-four hours, not including any part of a Saturday, Sunday, or legal holiday within which to respond to any such offer.

Rule 7 Closure of Claims and Petitions to Reopen

7-1 CLOSURE OF CLAIMS

(A) A claim may be closed by order, final admission, or pursuant to subsection (C) of this section.

(B) A Final Admission of Liability may be filed based on abandonment of the claim if the claimant:

(1) Is not receiving temporary disability benefits; and

(2) has not attended two or more consecutive scheduled medical appointments; and

(3) has failed to respond within 30 days to a letter from the insurer or the insured asking if the claimant requires additional medical treatment or is claiming permanent impairment. The letter shall be sent after the second missed medical appointment to the claimant and the claimant's attorney if the claimant is represented. The letter must advise the claimant in bold type and capital letters that failure to respond to the letter within 30 days will result in a final admission being filed. If the claimant timely responds to the letter and objects to closure the insurer may not file a Final Admission of Liability pursuant to this rule.

(a) If a claim is abandoned and a Final Admission of Liability is filed pursuant to this rule, date of maximum medical improvement shall not be included.

(b) A copy of the letter sent to the claimant as well as documentation of the missed appointments must be attached to the final admission of liability.

(c) If the claimant timely objects to a final admission of liability filed pursuant to subsection (b) of rule 7-1 the insurer must withdraw the final admission by filing a general admission of liability..

(C) When no activity in furtherance of prosecution has occurred in a claim for a period of at least 6 months, a party may request the claim be closed.

(1) Claimant must not be receiving temporary disability benefits.

(2) The request to close the claim shall include a separate, properly captioned proposed order to show cause and prepared certificate of mailing, along with addressed, stamped envelopes for the claimant, insurer and each attorney of record who has entered an appearance in the case. Requests may be submitted via regular mail. Email submission is permitted if email addresses are provided for all parties.

(3) Following receipt of a request to close a claim, the Director may issue the order to show cause why the claim should not be closed. If no response is mailed or delivered within 30 days of the date the order was mailed, the claim shall be closed automatically, subject to the reopening provisions of § 8-43-303, C.R.S. If a response is timely received, the Director may determine whether the claim should remain open. An application for hearing or for a division independent medical examination without further action (i.e., setting and attending a hearing or a division independent medical examination) does not automatically constitute prosecution.

(4) The Director may issue an extension of time to show cause to allow a party an opportunity to prosecute the claim. Any such extension of time to show cause shall not be reconsidered.

(D) Closure of a claim pursuant to 7-1(C) does not terminate entitlement to any of the following:

(1) maintenance medical benefits previously admitted and/or ordered.

(2) permanent medical impairment benefits previously admitted and/or ordered which have not yet been paid.

(E) A final admission of liability may be filed based on the claimant's voluntary abandonment upon written notice that the claimant no longer wishes to pursue the claim if the claimant:

(1) is no longer receiving temporary disability benefits; and

(2) acknowledges in the written notice upon a form prescribed by the division that the claimant is abandoning current and future medical care related to the claim;

(3) The claimant may object to a final admission of liability filed pursuant to 7-1(E).

7-2 PETITIONS TO REOPEN

(A) A claimant or insurer may request to reopen a claim, pursuant to §8-43-303, C.R.S. by filing an application for hearing with the office of administrative courts and endorsing the issue of reopening.

(1) If the other party agrees to voluntarily reopen the claim the Division shall be notified by the insurer by the filing of an admission

(2) If the claim is reopened pursuant to an order, the insurer shall file an admission consistent with the order within 20 days of the order becoming final.

(B) For those injuries arising after July 2, 1987 at 4:16 p.m. and prior to July 1, 1991, a Petition to Reopen shall be filed when a claimant is requesting a redetermination of the original permanent partial disability award pursuant to Section §8-42-110(3), C.R.S., (repealed 7/1/91). The petition shall be filed with a statement outlining the circumstances of termination from employment.

7-3 SINGLE LIFE EXPECTANCY TABLE

Age	Life Expectancy	Age	Life Expectancy	Age	Life Expectancy
0	82.4	39	44.6	78	11.4
1	81.6	40	43.6	79	10.8
2	80.6	41	42.7	80	10.2
3	79.7	42	41.7	81	9.7
4	78.7	43	40.7	82	9.1
5	77.7	44	39.8	83	8.6
6	76.7	45	38.8	84	8.1
7	75.8	46	37.9	85	7.6
8	74.8	47	37.0	86	7.1
9	73.8	48	36.0	87	6.7
10	72.8	49	35.1	88	6.3
11	71.8	50	34.2	89	5.9
12	70.8	51	33.3	90	5.5
13	69.9	52	32.3	91	5.2
14	68.9	53	31.4	92	4.9
15	67.9	54	30.5	93	4.6
16	66.9	55	29.6	94	4.3
17	66.0	56	28.7	95	4.1
18	65.0	57	27.9	96	3.8
19	64.0	58	27.0	97	3.6
20	63.0	59	26.1	98	3.4
21	62.1	60	25.2	99	3.1
22	61.1	61	24.4	100	2.9
23	60.1	62	23.5	101	2.7
24	59.1	63	22.7	102	2.5
25	58.2	64	21.8	103	2.3
26	57.2	65	21.0	104	2.1
27	56.2	66	20.2	105	1.9
28	55.3	67	19.4	106	1.7
29	54.3	68	18.6	107	1.5
30	53.3	69	17.8	108	1.4
31	52.4	70	17.0	109	1.2
32	51.4	71	16.3	110	1.1
33	50.4	72	15.5	111	1.0
34	49.4	73	14.8		
35	48.5	74	14.1		
36	47.5	75	13.4		
37	46.5	76	12.7		
38	45.6	77	12.1		

Rule 8 AUTHORIZED TREATING PHYSICIAN AND INDEPENDENT MEDICAL EXAMS

8-1 APPLICABILITY

(A) This rule applies to all employers unless specified below under paragraph (B) or (C) of this section.

(B) Employers that are health care providers or governmental entities that currently have their own occupational health care provider system pursuant to §8-43-404(5)(a)(ii)(A) may designate health care providers from their own system and are otherwise exempt from the requirement to provide a list of alternate physicians or corporate medical providers

(1) If emergency care is provided, an employer exempt under 8-1(B) shall designate an authorized treating physician as allowed by statute when emergency care is no longer required. If an exempt employer refers an injured worker to a physician who can attend the injured worker when the injury occurred while the worker was away from the worker's usual place of employment, such employer may designate an authorized treating physician pursuant to 8-1(B) within seven (7) business days following the date the employer has notice of the injury.

(2) If an exempt employer does not properly designate a health care provider from its own system the injured worker may select a provider of the worker's choosing.

(C) If an employer has a qualified on-site health care facility, the employer may designate that facility as the authorized treating physician.

(1) To be a qualified on-site health care facility, the on-site facility must be under the supervision and control of a physician, and a physician must be on the premises or reasonably available.

(2) If the employer designates an on-site health care facility, the employer must, within seven (7) business days following notice of an on the job injury, provide the injured worker with a designated provider list consistent with the provisions of Rule 8-2. While the on-site health care facility shall be the initial authorized treating physician, the injured worker may thereafter change to a physician or corporate medical provider on the designated provider list if the injured worker complies with all statutory and rule requirements for the one time change of physician.

8-2 DESIGNATED PROVIDER LIST

(A) When an employer has notice of an on-the-job injury, the employer or insurer shall provide the injured worker with a written list of designated providers from which the injured worker may select a physician or corporate medical provider. For purposes of this rule 8, the list will be referred to as the designated provider list.

(1) A copy of the written designated provider list must be given to the injured worker in a verifiable manner within seven (7) business days following the date the employer has notice of the injury.

(2) The designated provider list must include contact information for the insurer of record including address, phone number and claims contact information. If the employer is self-insured, the same contact information is required including the names and contact information of persons responsible for adjusting the claim.

(B) The designated provider list may include any combination of physicians and/or corporate medical providers so long as at least one physician or corporate medical provider is at a distinct location without common ownership. If there are not at least two physicians or corporate medical providers at distinct locations without common ownership within thirty miles of the employer's place of business the list may be comprised of providers at the same location or with common ownership.

(C) The number of physicians or corporate medical providers required on the designated provider list is determined by the number of physicians or corporate medical providers willing to treat an injured employee within thirty miles of the employer's location:

AVAILABLE PROVIDERS WITHIN 30 MILES:	REQUIRED NUMBER OF DESIGNATED PROVIDERS TO BE LISTED:
THREE OR LESS	ONE
AT LEAST FOUR BUT LESS THAN NINE	TWO
NINE OR MORE	FOUR

(D) A physician or corporate medical provider is presumed willing to treat injured workers unless the employer is specifically informed by the physician or corporate medical provider to the contrary.

(E) If the employer fails to supply the required designated provider list in accordance with this rule, the injured worker may select an authorized treating physician or chiropractor of their choosing.

8-3 EMERGENCY DESIGNATION

(A) In an emergency situation the injured worker shall be taken to any physician or medical facility that is able to provide the necessary care. When emergency care is no longer required the provisions of section 8-2 of this rule apply.

(B) If the injured worker is away from the worker's usual place of employment at the time of the injury, the injured worker may be referred to a physician in the vicinity where the injury occurred who can attend to the injury. Within seven (7) business days following the date the employer has notice of the injury the employer shall comply with the provisions of section 8-2 of this rule.

8-4 INFORMATION PROVIDED BY DESIGNATED PROVIDERS

(A) For the purposes of §8-43-404(5)(a)(I)(A), an interested party to a particular claim includes the injured worker, the attorneys of record, the employer, the insurer, and any third party administrator authorized to handle the specific claim.

(B) In order to provide information to assist in choosing a physician or deciding to change physicians, an interested party is entitled to receive a list of ownership interests and employment relationships involving the provision of medical care, if any, by making a written request for such information from a designated provider. A copy of the written request must be provided by the interested party to the respondents' representative(s). A physician who provides medical services on behalf of a corporate medical provider, but does not act as a primary care physician, is not subject to this provision. A designated provider shall utilize a form established by the Division to provide this information.

(1) The designated provider's list of ownership interests and employment relationships shall be current to within thirty (30) days of the date of the request.

(2) If the form was not previously provided and an interested party requests such information from a designated provider, the form shall be provided within five (5) business days of the request.

(3) If the information referenced in this paragraph (B) is provided, no follow-up questions or request for additional information shall be permitted, except for information allowed pursuant to a hearing or discovery process.

(C) If the list of ownership interests and employment relationships was not previously provided, and an interested party requests the information in compliance with the provisions of Rule 8-4(B) and the information is not provided in a timely manner, the interested party may notify the respondents' representative(s) in writing. To be effective, such notification must be made within seven (7) business days following the date the information should have been provided.

(1) Within seven (7) business days following timely notification pursuant to this paragraph (C), the injured worker shall be provided with a substitute authorized treating physician. If a substitute authorized treating physician is not timely furnished the injured worker may select an authorized treating physician of the worker's choosing.

8-5 ONE TIME CHANGE OF AUTHORIZED TREATING PHYSICIAN WITHIN NINETY DAYS

(A) Within ninety (90) days following the date of injury, but before reaching maximum medical improvement, an injured worker may request a one-time change of authorized treating physician pursuant to §8-43-404(5)(a)(III). The new physician must be a physician on the designated provider list or provide medical services for a designated corporate medical provider on the list. The medical provider(s) to whom the injured worker may change is determined by the designated provider list given to the injured worker pursuant to Rule 8-2 or 8-5(C).

(B) To make a change pursuant to this Rule 8-5 the injured worker must complete and sign the form established by the division for this purpose. The injured worker shall submit the form to the employer by mailing or hand-delivering the completed form to the person(s) designated by the employer to receive the form. The person(s) so designated is listed on the designated provider list given to the injured worker pursuant to Rule 8-2 or 8-5(C) as the respondents' representative(s). The injured worker may, but is not required to, provide the form to the impacted physicians. In any event, the respondents' representative(s) shall notify the impacted physicians and the individual adjusting the claim of the change, unless an objection is submitted pursuant to paragraph (C) of this Rule 8-5.

(C) If the insurer or employer believes the notice provided pursuant to this rule does not meet statutory requirements and does not accept the change of physicians, it must provide written objection to the injured worker within seven (7) business days following receipt of the form referenced in paragraph (B). The written objection shall set out the reason(s) for the belief that the notice does not meet statutory requirements.

(1) If the employer or insurer does not provide timely objection as set out in this paragraph (C), the injured worker's request to change physicians must be processed and the new physician considered an authorized treating physician as of the time of the injured worker's initial visit with the new physician.

(2) If written objection is provided and the dispute continues, any party may file a motion or, if there is a factual dispute requiring a hearing, any party may request that the hearing be set on an expedited basis.

8-6 TRANSFER OF MEDICAL CARE

(A) When there is a change of authorized treating physicians, the physician who had been the authorized treating physician remains authorized and is expected to provide necessary care until the injured worker's initial visit with the new authorized physician, at which time the treating relationship with the prior authorized treating physician shall terminate.

(B) The insurer or employer may facilitate the transfer of medical records to the new authorized physician. Otherwise, the new authorized physician should request medical records from the previous physician as soon as practicable. Upon receipt of a request for medical records, the physician receiving the request shall provide the medical records to the new physician within seven (7) calendar days following the physician's receipt of the request. If any copying is necessary the insurer shall pay for the copies consistent with the medical fee schedule.

(C) The insurer, employer or injured worker may schedule an appointment for the injured worker with the new authorized physician. If the new authorized physician is unwilling or unable to schedule an appointment to treat the injured worker, the injured worker shall notify the respondents' representative(s) in writing. Upon receiving such a notification, the respondents' representative(s) shall attempt to facilitate the scheduling of an appointment, which shall be scheduled to take place within thirty (30) days following the date of receipt of the notification. If a timely appointment cannot be scheduled and the injured worker does not agree to a later appointment, the injured worker shall be provided with a substitute authorized treating physician. If, within seven (7) business days following the date the respondents' representative(s) received written notice that the appointment could not be scheduled, an appointment is not scheduled or a substitute physician provided, the injured worker may select an authorized treating physician of the worker's choosing.

8-7 CHANGE OF MEDICAL PROVIDER UNDER §8-43-404(5)(A)(VI)

(A) In addition and separately from all the other provisions of this Rule 8, an injured worker may submit a written request to change physicians to the insurer or employer's authorized representative if self-insured. Such a request must be on the form prescribed by the division of workers' compensation.

(B) The insurer or employer's authorized representative if self-insured shall have twenty (20) days from the date of the certificate of service of the request form to either grant permission for the requested change of physician or object in writing on the form prescribed by the division of workers' compensation. Failure to timely object shall be deemed a waiver of objection.

8-8 INDEPENDENT MEDICAL EXAMINATIONS

(A) The following rules apply when the employer or insurer requests an independent medical examination to be conducted pursuant to §8-43-404. Prior to each such examination the employer or insurer shall ensure that the examining physician is provided written notice that describes the requirements relating to recording the examination as set out in statute and these rules.

(B) The examining physician shall provide both parties with a written medical report prepared as a result of the independent medical examination.

8-9 NOTICE TO CLAIMANT

(A) Prior to commencing the examination, the injured worker must review and sign a form issued by the Division that contains information regarding the independent medical examination process. A language interpreter may provide assistance if necessary. This form may be presented by the examining physician or by the employer, insurer or third-party administrator any time prior to the examination. The injured worker shall sign the form to reflect receipt of the information. The injured worker, examining physician and all parties are entitled to a copy of the signed form. The examination shall not take place unless the injured worker has signed the form. Refusing to sign the form shall constitute refusal to submit to the independent medical examination.

(B) Immediately prior to the examination, the examining physician shall verbally notify the injured worker that the examination will be audio recorded.

8-10 AUDIO RECORDING AND FEES

(A) The examining physician shall not alter the recording.

(B) The required audio recording shall be saved in a digital format. The examining physician shall retain the original recording.

(C) The examining physician shall be compensated for conducting the examination pursuant to the medical fee schedule, Rule 18-6(G)(4)-Special Reports.

(D) If a party requests a copy of the audio recording, regardless of which party makes the initial request, the first copy of the recording is provided only to the injured worker. If the injured worker makes the initial request for a copy of the recording, he/she shall be responsible for the cost of the copy. If the employer/insurer makes the initial request for a copy of the recording, it shall be responsible for the cost of the copy provided to the injured worker. The physician may require payment prior to releasing a copy of the recording.

8-11 PROCESS

(A) The recording shall not be released to anyone other than a party to the claim or the Division. This rule does not prohibit an employee or vendor of the examining physician or the Division from access to the recording for purposes of copying or transcribing the recording.

(B) Any party may request a copy of the recorded examination within twenty (20) days of the date the written medical report was issued. All requests for copies shall be made to the examining physician, in writing, with a copy of the request to all other parties. The written request shall include the address to which the copy is to be provided along with payment as defined in Rule 18.

(C) If the injured worker makes the initial request for a copy of the recording, the examining physician shall, within fifteen (15) calendar days of the date of the written request, provide a copy of the recording to only the injured worker.

(D) If the employer/insurer makes the initial request for a copy of the recording, the employer/insurer's written request shall instruct the examining physician to provide a copy of the recording only to the injured worker. The employer/insurer's written request must also provide the address for the injured worker. The examining physician shall provide a copy to the injured worker within fifteen (15) calendar days of the date of the written request.

(E) If the injured worker alleges that the recording contains medical information not relevant to the workers' compensation claim which should remain confidential, he/she must raise that allegation in writing within fifteen (15) calendar days of the date the copy of the recording was provided. The written allegation along with the copy of the recording and a copy of the written medical report received by the injured worker must be provided to the Division's Customer Service Unit. A copy of the written allegation shall also be provided to the examining physician and the employer/insurer. Within ten (10) days of the allegation being provided to the employer/insurer, the employer/insurer may file a response to the injured worker's allegation with the Division's Customer Service Unit. Failure to raise an allegation in a timely manner results in the injured worker having waived the right to raise any allegations of confidentiality in the recording.

(F) Only medical information that is not discussed in the written report generated by the physician as a result of the independent medical examination may be raised pursuant to paragraph (F) above. This limitation does not impact the injured worker's ability to challenge any aspect of the written report.

(G) A written allegation from an injured worker that the recording contains medical information that should remain confidential must provide a sufficient level of detail. A sufficient level of detail exists if the written statement provides general information as to what medical information was communicated that should remain confidential, and why the information should remain confidential within the context of the workers' compensation claim. Raising medical issues contained in the report, or failing to provide sufficient detail shall result in a summary denial of the allegation by an ALJ.

(H) If no timely allegation regarding confidential information pursuant to paragraph (F) is made, the employer/insurer may then request a copy of the recording by providing a written request to the examining physician, explaining that no allegation was made by the injured worker and a copy of the recording may be released to the employer/insurer. Payment to the examining physician shall be included with this request. The examining physician shall provide a copy of the recording within fifteen (15) calendar days of the date the written request is received.

(I) If the injured worker alleges that the recording contains confidential medical information as set out in paragraph (F) of this rule, the employer/insurer shall not request a copy of the recording until the allegation is resolved.

(J) If the Division receives an allegation pursuant to paragraph (F), the Division will submit the recording, a copy of the written medical report, the injured worker's allegation and any response from the employer/insurer to an Administrative Law Judge either in the Prehearing Unit or the Office of Administrative Courts.

(K) An Administrative Law Judge shall consider the injured workers' allegations and any response, listen to the recording in camera if necessary, and determine if the recording contains confidential medical information not relevant to the claim.

(L) If an Administrative Law Judge determines that the recording does not contain confidential medical information, the Administrative Law Judge will issue an appropriate order and return the recording to the injured worker. The employer/insurer may then request a copy of the recording within twenty (20) days of the date the order was issued by providing a written request, along with payment pursuant to Rule 18 to the examining physician. The examining physician shall provide a copy of the recording to the employer/insurer within fifteen (15) days calendar days of the date the written request is received.

(M) If an Administrative Law Judge determines that the recording contains confidential medical information, the Administrative Law Judge shall issue an order to the parties and the examining physician. The Administrative Law Judge shall then produce, or cause to be produced, a copy of the recording with the confidential medical information redacted. An order to redact information does not constitute a final decision as to the relevancy of that information in any future proceeding. The Administrative Law Judge will provide the original recording and the redacted recording to the Division's Customer Service Unit. The Division will maintain the copy of the original and redacted recording until the claim is closed. Either party may obtain a copy of the redacted recording by providing a written request, along with payment of $10, to the Division.

(N) If paragraph (M) applies and for any reason the Administrative Law Judge is unable to redact the recording, the Administrative Law Judge will issue an order that copies of the recording may not be released and will provide the copy of the original recording to the Division's Customer Service Unit. If necessary an Administrative Law Judge may thereafter review the recording in camera to assist in resolving factual disputes that may arise.

8-12 MAINTENANCE OF THE RECORDINGS

(A) Absent an order to the contrary, the examining physician may destroy the recording twelve (12) months after the date the examining physician's written report was issued.

(B) Any recording in the possession of the Division may be destroyed once the claim is closed.

8-13 DISPUTES

If a dispute arises, such as, the examination was not recorded, or if the recording is inaudible, the parties may file a motion with an Administrative Law Judge if they cannot agree on a resolution. Each dispute will be considered individually and determined based upon the specific facts in existence so that the Administrative Law Judge may fashion an appropriate remedy. Generally, the striking of the IME report will be the appropriate remedy. If the examining physician was responsible for the faulty or inaudible recording, the examining physician may be required to repeat the examination without additional payment. If another party was responsible for a faulty or inaudible recording that party may be required to pay for a repeat examination.

Rule 9 Division of Workers' Compensation Dispute Resolution

9-1 DISCOVERY

One of the goals of the workers' compensation system is to minimize litigation, but disputes do arise and a system for resolution is necessary. One of the underlying premises of an administrative adjudication system is that parties should be able to resolve disputes in, as much as possible, a quick, inexpensive and simple manner. Therefore, when discovery is authorized and appropriate, the following apply:

(A) Upon agreement of the parties or for good cause shown, an administrative law judge may allow additional discovery, may limit discovery or may modify the time limits set forth in this rule. Good cause shall include but not be limited to agreement of the parties or setting of a hearing on an expedited basis.

(B) Interrogatories and requests for production

(1) When a hearing application has been filed:

(a) Written interrogatories and requests for production of documents may be served upon each adverse party. The number of interrogatories, including the requests for production of documents, to any one party shall not exceed 20. These requests are tied to the most recent hearing application, but may carry over to a subsequent application upon agreement of the parties or by order.

(b) The interrogatories and the requests for production of documents may not be submitted later than 60 days prior to hearing, except for expedited hearings, agreement of the parties, or by order.

(c) Each party is under a continuing duty to timely supplement or amend responses to discovery up to the date of the hearing.

(2) When no hearing application has been filed:

(a) Interrogatories and requests for production of documents may only be served upon agreement of the parties or with an order for good cause shown that there are relevant and/or ripe issues in dispute.

(b) The number of interrogatories, including the requests for production of documents, to any one party shall not exceed ten (10), absent agreement of the parties or an order from an administrative law judge.

(3) When permitted, responses to interrogatories and production of documents shall be provided to all opposing parties within 20 days of service of the interrogatories and requests.

(4) Each interrogatory shall be answered separately and fully, in writing, unless it is objected to. Answers to interrogatories provided pursuant to this rule shall be treated as if under oath. All objections must be signed by the attorney making them.

(C) Depositions

(1) Depositions may be taken upon written motion and order, or by written consent of the parties, except that depositions of expert witnesses may be taken without an order upon agreement of the parties, provided the deposition is scheduled to occur no later than one (1) day prior to any hearing date. Expert testimony depositions may be scheduled after the hearing upon agreement of the parties or by order for good cause shown.

(2) Absent consent of the parties, permission to take a deposition of a party will be granted only when there is a specific showing:

(a) That a party who has been served with written interrogatories has failed to respond to the interrogatories; or

(b) That the responses to the written set of interrogatories are insufficient.

(3) A non-party witness may object to being deposed in writing to the requesting party within five (5) days of service of the subpoena.

(a) The subpoena must be accompanied by notice to the non-party deponent of the right to object in writing.

(b) If the non-party deponent objects, the requesting party may schedule a prehearing conference to request an order compelling the deposition.

(D) Discovery, other than depositions, shall be completed no later than 20 days prior to the hearing date, except for expedited hearings, agreement of the parties, or by order.

(E) If any party fails to comply with the provisions of this rule and any action governed by it, an administrative law judge may impose sanctions upon such party pursuant to statute and rule. However, attorney fees may be imposed only for violation of a discovery order.

(F) Once an order to compel has been issued and properly served upon the parties, failure to comply with the order to compel shall be presumed willful.

9-2 MEDIATION, SETTLEMENT CONFERENCES, PREHEARING CONFERENCES AND ARBITRATION

(A) Mediation. Parties to a dispute may consent to submit any dispute to mediation. A request for mediation may be presented to either the Division of Workers' Compensation or the Office of Administrative Courts. If all parties agree, a conference will be scheduled.

(B) Settlement Conferences. Parties to a dispute may request a settlement conference subject to the limitations set forth in § 8-43-206. Parties are encouraged to provide a settlement statement to the administrative law judge conducting the settlement conference at least 48 hours in advance of the settlement.

(C) Prehearing Conferences. The Director, administrative law judges in the Office of Administrative Courts, or any party to a claim may request a prehearing conference before an administrative law judge. Administrative law judges may order any party to a claim to participate in a prehearing conference.

(1) The issues raised for consideration may be raised by written or oral motion at the time of setting. At the time of setting, the party setting the conference shall notify the prehearing conference unit of the issues to be heard. The prehearing conference unit will notify all parties of the issues via e-mail.

(2) Within four (4) days of the setting, any party may add issues to be heard by providing written notice to the prehearing conference unit and all other parties.

(a) Issues added more than four (4) days after the setting may be heard at the discretion of the administrative law judge.

(3) A party may request additional time to respond to an issue raised at the prehearing conference. It shall be within the discretion of the administrative law judge to determine if such additional time is necessary to protect the rights of the parties.

(4) Once a prehearing conference has been requested by a party to a claim, it shall be set. If any party objects to the prehearing conference as set, the following procedures shall apply:

(a) A party objecting to the setting of a prehearing conference or refusing to participate in the conference shall e-mail, fax or hand-deliver any objections to the prehearing unit within four (4) days following the date the prehearing conference is set. If the administrative law judge orders that the prehearing conference proceed as set, the requesting party shall send written notice of the time and place of the prehearing conference to all other parties.

(5) Any party to a claim may request that the prehearing conference be recorded electronically either in advance or on the date of the prehearing conference. If a request for electronic recording is made, a party shall have until the date of the merit hearing, if such hearing date is pending at the time of the prehearing conference, or 100 days following the prehearing conference, whichever is shorter, within which to request that the prehearing conference unit provide a copy of the electronic recording.

(6) A party requesting a prehearing conference must make a good faith effort to confer with all opposing parties regarding both the proposed scheduling of the conference and the matters to be addressed at the conference at least one (1) day before setting the conference.

(D) Arbitration. Parties to a dispute may consent to submit any dispute to binding arbitration by written agreement. Binding arbitration shall be conducted by an eligible administrative law judge of the parties' mutual choice, or pursuant to arbitration procedures as provided by the Colorado Rules of Civil Procedure. Unless otherwise provided by the administrative law judge or upon mutual consent of the parties and/or upon the order of the arbitrator(s), proceedings in any such arbitration shall be conducted in a manner consistent with the Colorado Rules of Civil Procedure.

9-3 MOTIONS

(A) Director's Orders: All matters for the Director's determination shall be filed with the Division of Workers' Compensation, to the attention of the Director. Matters for the Director's determination include but are not limited to:

(1) Requests for penalties for consideration by the Director;

(a) Such motion shall state with specificity the grounds upon which penalties are being sought, and include all evidence upon which the requesting party is basing the request. If no response to the motion is filed, the Director may issue an order to show cause why penalties should not be imposed. failure to respond to the order to show cause may be deemed an admission of the facts alleged in the motion and a waiver of the right to be heard in response to the request for penalties.

(2) Requests for attorney fee determinations made by the Director;

(3) Matters regarding claims handling or administration, including, but not limited to, benefit distribution, petitions to modify, terminate or suspend temporary benefits, and lump sum requests;

(4) Requests for payment of costs of a transcript due to indigence pursuant to §8-43-213 (3);

(5) Closure orders;

(6) Matters involving uninsured employers;

(7) Utilization reviews, unless the Director has referred the matter on appeal;

(8) Disputes regarding medical payments, including requests to pay in excess of the fee schedule.

(B) Motions shall be filed exclusively with either the Division of Workers' Compensation or the Office of Administrative Courts. Duplicate copies of motions shall not be filed. Copies of these documents may be filed if required as attachments, evidence submissions, and other instances to complete the record for determination of a matter before the Director or an administrative law judge.

(C) Every motion must include a certification by the party or counsel filing the motion that he or she has conferred, or made a good faith effort to confer, with opposing counsel and unrepresented parties. If no conference has occurred, an explanation must be included in the motion.

(D) The motion shall conspicuously state in the caption if the motion is contested, uncontested or stipulated. If a motion is stipulated, or uncontested, the motion may be granted immediately.

(E) Any response or objection shall be filed within 10 days from the date the initial motion was filed. A response or objection must be simultaneously served on the opposing parties. The certificate of service must indicate that service was executed on the date of filing and indicate the method of service.

(F) The parties shall submit a proposed order with each motion and response. The proposed order shall be in editable format and shall include a certificate of service containing the e-mail addresses for all parties. The resulting order shall be sent by e-mail to all parties. If e-mail information is not available for all parties, the order shall be sent to the moving or prevailing party who is responsible for distribution of true and correct copies of the order to all remaining parties promptly, and in any event, no later than five (5) days after the date the order is received.

(G) Motions filed for consideration by the Director or an administrative law judge may be submitted via electronic mail and should be sent to the attention of either the Director's office or the prehearing unit, respectfully.

9-4 PRIVILEGES AND PRIVILEGE LOGS

(A) In discovery and disclosure disputes in which a privilege is being asserted (including but not limited to discovery and requests for claim files pursuant to §8-43-203) the party asserting the privilege shall prepare a privilege log with sufficient description to allow the other parties to assess the applicability of the privilege claims.

(B) The privilege log shall contain, at a minimum:

1. The date of the item for which the privilege is being asserted;

2. The author and recipient of the item;

3. A description of the subject matter sufficient to explain, without disclosing the substance of the allegedly privileged material, why the item qualifies for the asserted privilege;

4. The legal and factual basis for the claim of privilege;

5. If the privileged item contains a communication, the names and titles of the parties to that communication;

6. The page or bates number of the item for which privilege is asserted.

9-5 TRUST DEPOSITS AND SURETY BONDS

(A) The Director's office shall be designated as trustee for purposes of §8-43-408(2). When the provisions of §8-43-408 apply, an administrative law judge or the Director shall compute, using the best information available, the present value of the total indemnity and medical benefits estimated to be due on the claim. The employer shall provide the funds so ordered by check within ten days of the order. The trustee shall pay an amount to bring the claim current, and continue to pay the claimant benefits on a regular basis in an interval and amount ordered by an administrative law judge or the Director. The trustee shall also make payments for medical services consistent with the order of an administrative law judge or the Director. Any interest earned shall accrue to the benefit of the trust. The amount ordered to be placed in trust can be amended from time to time, and any excess amount shall be returned to the employer. The trustee shall make such disbursements as appropriate so long as funds are available, and shall not be subject to penalties or any other actions based on administration of the trust.

(B) In the alternative to the establishment of a trust, the employer shall provide a bond as set forth in §8-43-408(2). In the event that the employer fails to bring the claimant current with medical and indemnity benefits owed, or fails to continue to pay the claimant such benefits on a regular basis in an interval and amount ordered by an administrative law judge or the Director, the surety will be obliged to do so. The surety's liability to fulfill such obligation shall extend to the amount fixed, which can be amended by order, and exist in the form prescribed by the Director.

(C) Any disputes about the proper disbursement of funds in the trust shall be made to the Director or an administrative law judge for determination.

9-6 CONSOLIDATION AND MERGER OF CLAIMS

(A) Two or more claims or applications may be consolidated for hearing or other purposes upon the order of an administrative law judge or the Director for good cause shown.

(B) Duplicate claims may be merged into one file with one workers' compensation number upon the order of an administrative law judge or the Director. Merger of files shall be requested via motion specifying the surviving workers' compensation number and any other identifying information requested by the Division.

(C) No motion will be required in instances where a duplicate claim has been created as the result of a typographical error in the claimant's social security number or the date of injury. When duplicate claims exist as a result of such an error, the claims may be merged upon written request to the Division, with copies to all parties identifying the typographical error and supplying the correct information. The parties must confirm that the request to merge is unopposed. If the parties are unable to confirm that the request is unopposed, a motion to the prehearing unit is required.

9-7 ATTORNEY REPRESENTATION

(A) To represent a party in a claim at the Division of Workers' Compensation, an attorney shall file an entry of appearance with the Division.

(B) When a claim has closed or the claim has settled on a full and final basis, an attorney may withdraw by filing a notice of withdrawal sent to the client and all parties.

(C) When a claim is not closed, an attorney may withdraw by filing a substitution of counsel signed by both the attorney withdrawing and the attorney entering the claim and sent to all parties. Otherwise, an attorney must request an order allowing withdrawal from the claim by filing a motion to withdraw, including the required notice. The motion must be sent to the client and all parties. The notice must contain all of the following:

(1) A statement that the attorney wishes to withdraw;

(2) A statement that the client is responsible for keeping the Division of Workers' Compensation and the other parties informed of the client's current address and telephone number;

(3) A statement that the claim may be closed if no further action is taken;

(4) The date scheduled for any future hearings, the dates by which any pleadings or briefs are to be filed (including, if applicable, the date by which any objection to an admission must be filed); and notice that these dates will not be affected by the withdrawal of counsel;

(5) A statement that the client may object to the withdrawal by filing a written objection within 10 days of the date on the certificate of mailing of the notice, and mailing a copy of the objection to the attorney and the Division of Workers' Compensation.

9-8 SETTLEMENT PROCEDURES

(A) When the parties enter into a full and final settlement of a claim, they shall use the form settlement agreement prescribed by the Division of Workers' Compensation. The parties shall not alter the prescribed form, except as set out in this rule. Parties who are settling a claim for a fatality are not required to use the Division's prescribed form settlement agreement.

(B) The parties may include terms in paragraph 9(A) that are both specific to that agreement and involve an issue or matter that falls within the Workers' Compensation Act.

(C) The parties may reference exhibits attached to the agreement in paragraph 9(B) of the settlement agreement. These exhibits may include a workers' compensation Medicare set-aside arrangement (WCMSA) or other information related to the workers' compensation claim.

(D) The parties may attach other written agreements to the prescribed form and shall list these agreements in paragraph 9(C) of the settlement agreement. These other written agreements may include an agreement involving employment, or a waiver of a claim for bad faith.

(E) Any exhibits and/or agreements attached to a settlement agreement pursuant to subsections (C) or (D) above are included for the convenience of the parties and shall not be reviewed by the Division. Approval of the settlement agreement does not constitute approval of any attachments to the settlement agreement.

(F) The monetary amount of the settlement as reflected in the written agreement shall not include any consideration for any agreements which fall outside the jurisdiction of the Division of Workers' Compensation.

(G) The parties shall file the settlement agreement and a completed settlement routing sheet with a proposed order in the form prescribed by the Division. The settlement agreement must be signed by all parties with the claimant's signature verified by a notary public consistent with the notaries public act. The filed copy of the agreement will be retained by the Division. The parties will be responsible for retaining a copy for their records. The completed order will be distributed in accordance with the attached certificate of service. If the parties request the order be returned via the U.S. postal service, self-addressed stamped envelopes must be supplied for all parties.

(H) The settlement agreement must be accompanied by a statement from the claimant on the Division provided form indicating if an appropriate in-person advisement has occurred, if the right to an in-person advisement is waived, and/or if a telephone or online advisement by Division staff is requested.

(1) A self-represented (pro se) claimant who has waived advisement may withdraw the waiver in writing and request either an in person or telephonic advisement, provided a written notice of withdrawal is received by the Division within three (3) days of the settlement documents being signed.

(I) The Division's prescribed form settlement agreement should be used for full and final settlements only. Parties requesting approval of a stipulation resolving one or more issues in dispute shall instead submit a motion for approval of joint stipulation to the Director or an administrative law judge.

9-9 CLAIM FILES

(A) The file at the Division of Workers' Compensation will be retained until the claim is closed and is not subject to subpoena for administrative hearings. The file will be retained for at least seven (7) years from the date of closure. Certified copies of any documents in the Division file can be tendered by a party to the Office of Administrative Courts and shall be considered self-authenticating. Parties may obtain certified copies of documents in the Division file by contacting the Division of Workers' Compensation, customer service section.

(B) Absent extraordinary circumstances, no employee of the Division of Workers' Compensation shall be expected or required to testify at a hearing.

9-10 DISFIGUREMENT AWARD (PHOTO)

(A) Requests for determination of additional compensation for disfigurement based upon submission of photographs shall be filed on the form prescribed by the Division.

(B) Requests shall be accompanied by at least one (1) photograph, clearly showing the disfigurement, taken after the injured worker has been placed at maximum medical improvement, or at least six (6) months after the disfiguring event. It is strongly encouraged that a ruler be visible in the photograph next to the disfigurement. Video submissions will not be accepted.

(C) Claimants are required to certify that the submitted photographs are a true and accurate representation of the disfigurement at the time the request is being made.

(1) The injured worker should sign and date on the back of each photograph. The date the photograph was taken shall also be listed, if different than the date of signature.

(2) The signature shall serve as the certification that the photographs are a true and accurate representation of the disfigurement at the time the request is being made.

(3) If the photograph is provided digitally, a signed certification must accompany the image(s).

(D) Any party dissatisfied with an order regarding disfigurement benefits issued pursuant to this rule may file an application for hearing before the Office of Administrative Courts.

Rule 10 Medical Utilization Review

10-1 REQUESTS FOR UTILIZATION REVIEW

(A) A party shall request a utilization review by filing the Request for Utilization Form (request form) with the Division Utilization Review Coordinator. The request form must be the one prescribed by the Division, but a duplicated or reproduced request form may be used as long as it is an exact version of the original in both appearance and content.

(B) The provider under review shall remain as an authorized provider for the associated claimant during the medical utilization review process. The provider shall continue to submit bills for services rendered to the associated claimant during the review period and the insurance carrier shall continue to pay the provider's bills as provided in these rules of procedure.

(C) As provided in section 10-2, below, an information package and medical records package shall be filed with the request form.

10-2 FILING A REQUEST FOR UTILIZATION REVIEW

(A) One copy of an information package shall be filed and shall contain the following items:

(1) completed and signed Division prescribed request form.

(2) copies of all admissions filed or orders entered in the case.

(3) a list containing the full names and medical degrees of all providers, including the provider under review, other treating providers, and individuals who are considered as referrals or who performed consultations, independent medical examinations and/or second opinions, and

(4) The minimum filing fee as provided in section 10-2(E)

(B) In addition, seven (7) copies of a medical records package shall be filed in accordance with the instructions on the prescribed request form, Each copy shall be two-hole punched at the top center of each page and securely fastened. (Notebooks and plastic type covers and binders shall not be used). A blank sheet of paper shall be placed and bound to the front and back of each copy of the submitted material and if tabs are used to divide sections, they shall be positioned to the right side of the document and each copy shall contain the following items:

(1) A table of contents;

(2) A case report, which shall be prepared, signed and dated by a licensed medical professional. This report shall be dated within thirty (30) days prior to the date of filing with the Division pursuant to §8-43-501(2)(b). The case report shall be limited to the following:

(a) name, discipline of care and specialty of the provider under review,

(b) claimant's standard demographic information (age, sex, marital status, etc.),

(c) claimant's employer and occupation/job title, date(s) of claimant's work-related injury/exposure(s), and,

(d) Date of initial treatment, a brief chronological history of treatment to the present date, and any significant contributing factors which may have had a direct effect on the length of treatment; (e.g., diabetes).

(e) A brief statement from the medical professional after review of the medical records in support of utilization review.

(3) The following sections:

Section 1 – a copy of the Employer's First Report of Injury and/or the Worker's Claim for Compensation form.

Section 2 – all reports, notes, etc., from the provider under review as submitted to the requesting party.

Section 3 – all reports, notes, etc., of the other treating providers as submitted to the requesting party.

Section 4 – all reports resulting from referrals, consultations, independent medical examinations and second opinions as submitted to the requesting party.

Section 5 – all diagnostic test results as submitted to the requesting party.

Section 6 – all medical management reports as submitted to the requesting party.

Section 7 – all hospital/clinic records related to the injury as submitted to the requesting party.

(C) The medical records package shall not contain billing statements, adjustor notes, vocational rehabilitation records, surveillance tapes or reports, admissions, denials or comments directed to the utilization review committee.

(D) All material contained in the medical records package shall be presented in identified sections, each section's contents presented in chronological order.

(E) A minimum filing fee of $ 1,250.00 shall be paid at the time of filing by the requesting party. The Division will notify the requesting party of additional costs incurred, such as payment to panelists not covered by the filing fee, which require a supplemental fee. Payment of any such supplemental fee will be required for completion of the utilization review and prior to the issuance of the Director's order.

10-3 OFFICIAL NOTIFICATION OF UTILIZATION REVIEW

(A) The Division will notify in writing the provider under review of the review request, and provide a copy of the written notification to each party to the case.

(B) Along with the written notification, the provider under review, as well as each party to the case, will receive one copy of the medical records package as filed by the requesting party.

(C) Within seven (7) days of receiving the written notification, the provider under review may submit a concise written statement no longer than two (2) pages in length, limited to whether the treatment provided was reasonably necessary or reasonably appropriate. The provider shall supply seven (7) copies of the statement to the division. A timely and properly submitted written response will be added to the review packets and forwarded to all parties by the division.

(D) Any motions or requests regarding the utilization review must be submitted, in writing, to the Medical Utilization Review Coordinator. Until such time as the Director issues a final order, the medical utilization review is an internal process at the Division, under the jurisdiction of the Director.

10-4 ADDING MEDICAL RECORDS TO THE UTILIZATION REVIEW FILE

(A) The Division will not accept additional medical records filed by any individual who has not been identified as a party to the case.

(B) The Division will incorporate all properly and timely filed additional medical records into the review file. Additional medical records that are not filed timely and properly will not be included in the review file.

(C) Parties filing additional medical records should not duplicate records already submitted for review. Seven copies of any additional medical records must be provided.

(D) The provider under review and each party to the case shall have one opportunity to submit additional medical records. Medical records must be received or postmarked within thirty (30) days from the mailing of the review notification. This thirty (30) day period can be extended upon a written request which sets forth good cause.

(E) Any additional medical records shall be presented as follows:

(1) The first item in each copy shall be a dated and signed transmittal letter which contains the following information:

(a) The UR# and claimant's name,

(b) Identification of the submitting party name and relationship to the case,

(c) a certification stating the seven (7) copies of additional medical records contain the same documents, and

(d) an index of the additional attached medical records material.

(2) The presentation of any additional medical records shall be in an identical manner to those as provided in section 10-2(B), above.

(F) The Division will send the provider under review and each party to the case a copy of all properly filed additional medical records.

10-5 Selection of Utilization Review Committee Members

(A) The Director, with input from the Medical Director, shall appoint appropriate peer professionals to serve on the utilization review committees for three years.

(B) A committee member may be suspended from participation if the member has been the subject of a utilization review which resulted in an order for change of provider, retroactive denial of payment of medical bills and/or revocation of accreditation.

(C) Committee members shall be paid a fee of $225 per hour for their time incurred in preparing and completing their reports and recommendations to the director. Services rendered by the committee members on behalf of the Division shall be concluded upon acceptance by the Division of their final reports and recommendations. Any party to a claim for benefits or any party to a utilization review proceeding who requests the presence as a witness of one or more committee members at a proceeding for any purpose, by subpoena or otherwise, shall be responsible for payment to said committee member(s) pursuant to the fee schedule set forth in these rules of procedure.

(D) A provider may not serve on a UR Committee unless his or her professional license or certification, if applicable, is current, active and unrestricted.

(E) After the members of the utilization review committee have been established, the provider and each party to the case will receive written notice of the names of the committee members. Within ten (10) days of receiving the written notification, any allegation that a committee member has a conflict and should be removed from the committee must be submitted in writing to the medical utilization review coordinator, setting forth the basis for the alleged conflict. Any such allegations that are not raised in a timely manner are deemed to have been waived and will not be considered at any subsequent stage of the utilization review proceedings. A conflict will be presumed to exist when the provider under review and a member of the review committee have a relationship which involves a direct or substantial financial interest. The following guidelines apply to any allegations of conflict under this Rule:

(1) Direct or substantial financial interest is a substantial interest which is a business ownership interest, a creditor interest in an insolvent business, employment or prospective employment for which negotiations have begun, ownership interest in real or personal property, debtor interest or being an officer or director in a business.

(2) The relationship will be reviewed as of the time the utilization review is being conducted. Relationships in existence before or after the review in and of themselves will have no bearing, unless a direct or substantial financial interest is raised at the time of the utilization review.

(3) Being members of the same professional association or medical group, sharing office space or having practiced together in the past are not the types of relationships which will be considered a conflict, absent a direct or substantial financial interest.

(4) Any provider who has provided services to the claimant in the case for which the utilization review has been requested, or who has any type of personal or professional relationship with the claimant, will not be allowed to serve on the utilization review committee.

(5) This rule is not intended as an opportunity to conduct discovery. Depositions, interrogatories or any other type of discovery will not be permitted in order to make determinations as to whether a conflict exists.

(F) Members of UR Committees shall not review any material other than what is provided by the Division, and shall not engage in communication regarding the Utilization Review with

any person other than Division staff, except under the following circumstances: by approval of the Director; by written agreement of the parties to the case, including the provider under review; the provider under review and the parties to the case are strictly prohibited from having any communication with the members of the UR committee while the review is pending.

10-6 COMPOSITION OF UTILIZATION REVIEW COMMITTEES

(A) The Division will strive to compose utilization committees that reflect a balance of interests. Membership of the committees may include the following:

(1) Joints/Musculoskeletal Committee – Two practitioners licensed in the same discipline of care as the provider under review and one occupational medicine practitioner (M.D. or D.O.) with a minimum of 2 years experience in occupational medicine where 30% of practice time is in occupational medicine cases or a minimum of 5 years of experience with a minimum of 15% of practice time in occupational medicine cases;

(2) Dental Committee (Teeth only) – three dentists;

(3) Psychiatry Committee – One occupational medicine practitioner (M.D. or D.O.) and two psychiatrists; and,

(4) Other – Committee shall be determined by the Director to meet the specific circumstances of the utilization review case.

10-7 RESPONSIBILITIES OF UTILIZATION REVIEW COMMITTEE MEMBERS

(A) Each committee member shall perform the review based on the materials provided, and work independently while performing his/her review. The review shall be a paper review only unless a specialist opinion is requested by a majority of the committee members. The specialist's opinion may require a physical examination of the claimant.

(B) When performing a utilization review, the members of the medical utilization review committee shall consider all applicable medical treatment guidelines under these rules of procedure. The Division shall provide copies of the appropriate guidelines to the committee upon request.

(C) The report of each member of the utilization review committee should be limited to answers to the specific questions submitted by the Division, along with a written narrative supporting or explaining the answers for each of the questions.

10-8 CHANGE OF MEDICAL PROVIDER

(A) If the Director orders that a change of provider be made, the claimant and insurer or self-insured employer shall follow the procedures set forth in §8-43-501(4) in order to obtain a new provider. The parties shall notify the Division, on the prescribed form, as to whether the parties have agreed upon a new provider or whether the Director shall select the new provider as provided in §8-43-501(4).

(B) If the claimant chooses to remain under the care of the provider under review during the period of appeal resolution, the payor shall be responsible for payment of medical bills to the provider until an order on appeal is issued. If the insurance carrier, employer or self-insured employer prevails on appeal, the claimant may be held liable by the prevailing party for such medical costs paid during the appeal period.

(C) A provider who wishes to become a new treating provider candidate shall not be eligible unless his or her professional license or certification, if applicable, is current, active and unrestricted.

10-9 UTILIZATION REVIEW APPEALS

(A) The appealing party shall complete the appeal form prescribed by the Division. The form shall be filed with the Medical Utilization Review coordinator within the timeframes set forth in the appeal procedures.

(B) Should the Director order both retroactive denial of fees and change of provider, upon appeal the issues shall be separated and transferred to the Office of Administrative Courts for a de novo hearing on retroactive denial or a record review for change of provider.

(C) Should the appealing party be entitled to a de novo hearing, the hearing shall be scheduled according to the instructions on the appeal form. The appealing party must file an application for hearing with the Office of Administrative Courts and a copy must be provided to the Medical Utilization Review Coordinator.

Rule 11 Division Independent Medical Examination

This rule applies to parties and physicians participating in the Division Independent Medical Examination (DIME) program pursuant to the Workers' Compensation Act of Colorado, § 8-40-101, et seq. ("The Act"). When used in this rule, Administrative Law Judge (ALJ) refers to Administrative Law Judges in the Office of Administrative Courts or Prehearing Administrative Law Judges employed by the Division of Workers' Compensation.

11-1 QUALIFICATIONS

A physician seeking appointment to the DIME panel pursuant to The Act, shall meet the following qualifications:

(A) Be licensed with no restrictions by the Colorado Medical Board, the Colorado Dental Board, the Colorado Board of Chiropractic Examiners, or the Colorado Podiatry Board. Physicians licensed by the Colorado Medical Board must be board-certified or board eligible by the American Board of Medical Specialties, the American Osteopathic Association, or the National Board of Physicians and Surgeons.

(B) For determination of maximum medical improvement (MMI), have attained at least Level I accreditation and engaged in at least 384 hours of direct patient care (excluding medical/legal evaluation) during the past five calendar years.

(C) For determination of permanent impairment and MMI, have attained Level II accreditation and either:

(1) engaged in at least 384 hours of direct patient care (excluding medical/legal evaluation) during the past calendar year OR

(2) engaged in at least 384 hours of direct patient care (excluding medical/legal evaluation) during the previous five years and demonstrated additional competency in the field of disability evaluation through certification by the American Board of Independent Medical Examiners, the International Academy of Independent Medical Evaluators, or equivalent continuing medical education courses.

(D) A physician who is selected to perform a DIME as a result of an agreement by the parties and who has not been appointed to the DIME panel is not required to apply for appointment; however, such physician shall comply with all other qualifications and rules governing the DIME proceedings.

11-2 COMPUTATION OF TIME

In computing any period of time prescribed or allowed by this rule, the parties shall refer to Rule 1-2. All references to "days" shall mean calendar days unless otherwise stated. All references to "years" shall mean twelve calendar months.

11-3 DIME PHYSICIAN COMPLIANCE

A physician seeking appointment to the DIME panel shall complete the Request for Appointment to the Independent Medical Examination Panel in full, including the required certification. Upon approval of the application, the physician shall:

(A) Comply with The Act and the Workers' Compensation Rules of Procedure;

(B) Complete a summary disclosure form;

(C) Conduct all DIMEs in an objective and impartial manner;

(D) Decline a request to conduct a DIME only with approval by the Director or an ALJ on the basis of good cause shown;

(E) Not evaluate the claimant if an actual conflict of interest exists. A conflict of interest includes, but is not limited to, instances where the physician or someone in the physician's office has treated the claimant or performed an Independent Medical Examination (IME) on the claimant. A conflict is presumed to exist when the DIME physician and a physician who previously treated or evaluated the claimant in the course of an IME have a relationship involving a direct or substantial financial interest during the pendency of the DIME.

(1) Direct or substantial financial interest is defined as a business ownership interest, a creditor interest in an insolvent business, employment relationship, prospective employment for which negotiations have begun, ownership interest in real or personal property, debtor interest, or being an officer or director in a business.

(2) Being members of the same professional association, society, or medical group, sharing office space, or having practiced together in the past are not the types of relationships that will be considered a conflict;

(F) Not engage in communication regarding the DIME with any person other than Division Staff, except under the following circumstances:

(1) The claimant during the DIME;

(2) The requesting party to set the appointment;

(3) The submitting party when discussing the format of the medical records;

(4) The paying party to discuss issues regarding the invoice;

(5) The parties negotiating selection of the DIME physician and agreed upon fees pursuant to sections 11-4(A) or 11-7(B). All communications with potential DIME physicians in furtherance of these negotiations shall involve all parties to the claim.

(6) By order of the Director, an ALJ or by written agreement of all parties;

(7) The parties to discuss payment for review of extensive medical records in accordance with section 11-5(C). Any such communication must be in writing, with copies to both parties and the DIME Unit.

(G) Not become the treating physician for the claimant, unless ordered by the Director or an ALJ, or by written agreement of all parties;

(H) Not refer the claimant to another physician for treatment or testing unless an essential test is required;

(I) Not employ invasive diagnostic procedures unless approved by the parties or an ALJ;

(J) Not substitute any other physician as the DIME physician, unless ordered by the Director or an ALJ, or by written agreement of all parties;

(K) For each DIME assigned, make all relevant findings regarding MMI, permanent impairment, and apportionment of impairment, unless otherwise ordered by an ALJ.

(L) Within twenty (20) days of the examination submit to the Division and all parties the original report with all attachments. The twenty (20) day deadline for the insurer to file an admission of liability or request a hearing pursuant to § 8-42-107.2(4)(c), does not begin to run until the DIME Unit has issued a notice to all parties that it has received a sufficient report. The report shall conform to the DIME Report Template.

11-4 DIME PROCESS

(A) Application and scheduling:

(1) Either party disputing a determination of MMI or impairment made by an authorized treating physician in a workers' compensation case must apply for a DIME by filing the Notice and Proposal and Application for a DIME form within thirty (30) days after the date of mailing of the final admission of liability or the date of mailing or physical delivery of the disputed finding or determination, as applicable, pursuant to § 8-42-107.2(2)(a) and (b). The party applying for a DIME pursuant to § 8-42-107(8)(b), shall meet all statutory conditions prior to filing the form. The requesting party may amend the Application for a DIME form only by order of an ALJ or written agreement of all parties.

(2) The parties must attempt to negotiate the selection of a physician to conduct the DIME. The requesting party shall propose one or more candidates qualified under section 11-1 on the Notice and Proposal and Application for a DIME form. The Notice of DIME Negotiations form shall be filed within thirty (30) days of the filing of the Notice and Proposal and Application for a DIME.

(a) If the parties have agreed on the DIME physician and fee, either party may file the form indicating the name of the physician.

(i) The parties and the DIME physician may agree to the fees set forth in 11-5(A)(1) – (3) or to any other fee as provided by 11-5(A)(4). The parties shall indicate the agreed upon fee on the Notice of DIME Negotiations form. The form shall be signed by the DIME physician and all parties to the claim.

(ii) If the parties cannot reach agreement regarding the fee with the agreed upon physician, they shall proceed with the selection process set forth in 11-4(A)(3)-(5).

(b) If the parties have not agreed on the DIME physician, the insurer shall file the form.

(3) The Division will notify the parties in writing of the names and the medical specialties of three physicians or of the agreed-upon physician within five (5) days of receiving the Notice of DIME Negotiations form.

(4) Within five (5) business days of issuance of the three-physician list by the Division, a party may request summary disclosures concerning any business, financial, employment, or advisory relationship with the insurer or self-insured employer. Such request shall be submitted by electronic mail to the DIME Unit and copied to the other parties. The parties may use the information provided on the summary disclosure forms to assist in the decision to strike a physician. The information shall not be used as a basis for the Division to remove a physician from the three-physician list. Physicians who are agreed-upon to perform DIMEs pursuant to § 8-42-107.2(3)(a), are not required to comply with this subsection.

(5) Within five (5) business days of issuance of the three-physician list by the Division, the requesting party shall strike one name and inform the other party and the Division. The other party then shall have five (5) business days to strike one of the remaining physicians and inform the DIME Unit in writing, with confirmation to the requesting party. If the Division is not notified of the selected physician within ten (10) business days of the issuance of the three-physician list, the Division shall randomly select one name from the remaining physicians.

(6) The Division shall confirm to the parties in writing the name of the selected or agreed-upon physician.

(7) If the selected physician is unable to perform the DIME or if a physician is removed from the panel for any reason other than having been struck by a party, the Division shall provide one replacement name to the original list of three physicians, and present that revised list to the parties where each shall strike one name according to the procedures set forth in this section.

(8) The requesting party shall schedule the DIME with the physician within fourteen (14) days of receiving the DIME physician confirmation. The requesting party shall immediately notify the DIME Unit and the opposing party in writing of the date and time of the examination. Absent good cause as determined by the Director or an ALJ, failure to make the appointment and advise all parties within fourteen (14) days may result in a Director's order to show cause why the DIME process should not be terminated.

(9) The examination shall be scheduled no earlier than 45 days or later than 75 days after the requesting party receives the notice of the DIME physician confirmation unless otherwise ordered by the Director or an ALJ, or by written agreement of all parties.

(10) Once a three-physician list has been issued, it will, to the extent possible, remain the same for all future DIME applications. Physicians may be replaced at the discretion of the Division for subsequent DIME applications due to new circumstances following the issuance of the initial list. Such new circumstances necessitating physician replacement may include, but are not limited to, requested body parts or issues, or availability of the physician(s).

(B) Medical Records:

(1) The medical records packet shall include all records regarding the diagnosis, treatment, and evaluation of the claimant's work-related injury(ies) or disease(s), as well as any relevant pre-existing condition(s), injury(ies), or disease(s), if applicable and available. Each page shall be Bates-stamped. The parties may agree in writing to exclude any records. The party seeking to exclude any records without agreement of the other parties must request a prehearing conference before an ALJ.

(2) Surveillance recordings, depositions, vocational rehabilitation reports, non-treating case manager records, prior orders and other records may not be submitted without written agreement of all parties or by order of an ALJ. The party seeking to include the above records without agreement of all other parties must request a prehearing conference before an ALJ.

(3) The medical records packet shall include a dated cover sheet listing the claimant's name, DIME physician's name, date and time of the appointment, and the Division workers' compensation number. The records shall be in a chronological order, beginning with the earliest record, and tabbed by year. The packet shall not contain duplicative records. The packet also shall include a chronological index of the records, beginning with the earliest record. The index shall list the Bates-page number, the date, and the provider corresponding to each record.

Each of the following inpatient medical records shall correspond to an individual entry on the index:

- admission notes;
- discharge summaries;
- operative reports; and
- diagnostic tests other than blood tests.

All other inpatient medical records from the same inpatient stay shall correspond to a single entry on the index. The index entry shall list the name of the facility as the provider.

(4) Records may be provided electronically by agreement of the parties and the DIME Physician so long as the records otherwise comply with the formatting requirements of this paragraph.

(5) The insurer shall serve the claimant with a complete copy of the initial packet no later than fourteen (14) days from the date the Division confirms the selected DIME physician. The claimant shall serve the insurer with any additional relevant records, in the format compliant with this section, no later than ten (10) days after receiving the initial packet, or twenty-four (24) days after the date the Division confirms the selected DIME physician, whichever comes later. The insurer shall serve the DIME physician with the final packet no later than fourteen (14) days prior to the scheduled examination. At the time the final packet is served on the DIME examiner, the insurer shall provide Claimant with an identical copy of the final packet. If no party has supplemented the initial DIME packet previously exchanged with Claimant, then the insurer shall affirm that fact in the letter to the DIME unit and Claimant. In such an instance, the insurer does not need to reproduce the previously exchanged DIME packet. For purposes of this rule, date of service shall be determined by the verifiable date of delivery.

(6) Failure to timely and properly submit records may result in termination or rescheduling of the DIME by the Director, at the cost to the defaulting party. The DIME physician has discretion to impose a $250.00 non-compliant records fee on the defaulting party. In addition, other penalties available under these rules and the Act may be determined by the Director. Any disputes regarding the contents of the final medical records packet may be resolved by an ALJ. Disputes regarding responsibility for default may be addressed by the ALJ or the dispute resolution process set forth in Rule 16.

(7) Submission of supplemental records requires a prior order by an ALJ finding good cause. Supplemental records shall be prepared pursuant to this section (B) and must be served by any party concurrently to the DIME physician and all other parties no later than seven (7) days prior to the DIME examination. If the addition of supplemental records causes the total records packet to exceed applicable page counts in subsection 11-5(A)(4), additional record review fees will apply pursuant to that subsection.

(C) The parties may agree to limit the issues to be addressed in the DIME in writing and signed by both parties. The written agreement may use the optional Notice of Agreement to Limit the Scope of the DIME form. The parties must include the agreement in the medical records packet served on the DIME physician, immediately following the chronological index and must provide a copy of the agreement to the DIME Unit.

(D) The claimant shall notify the insurer of the necessity for a language interpreter no later than fourteen (14) days before the examination. The insurer shall be responsible for arranging for the services of and paying for such language interpreter. The language interpreter shall be impartial and independent, and have no professional or personal affiliation with any party to the claim or the DIME physician.

(E) An order by an ALJ is required to hold the proceedings in abeyance once an appointment has been scheduled. The party filing a motion to hold the proceeding in abeyance shall be considered the defaulting party for purposes of paying all applicable rescheduling or termination fees to the DIME physician.

(F) Prior to the examination, the DIME may be terminated by the requesting party or by order. Following the examination, the DIME may be terminated only by agreement of the parties or by order.

11-5 PAYMENTS/FEES

(A) The fees stated in Rule 11 shall be the only fees that may be billed or charged for DIMEs, except as set forth in subsection (4) below. The base DIME fee will be determined based upon the length of time elapsed between the date of injury and the filing of the notice and proposal, as well as body regions identified on the DIME application in accordance with the following schedule:

(1) Less than two years after the date of injury and/or less than three body regions: $1,000;

(2) Two or more years but less than five years after the date of injury and/or three or four body regions: $1,400;

(3) Five or more years after the date of injury and/or five or more body regions: $2,000.

(4) If the medical records exceed the page counts below, additional record review fees will apply:

$1,000 DIME 500 pages

$1,400 DIME 750 pages

$2,000 DIME 1,000 pages

The additional record review fees are calculated at the rate of $1 for each page that exceeds these page counts.

(5) The DIME fees do not apply if the parties have agreed on the DIME physician and fee pursuant to section 11-4(A)(2)(a)(i).

(B) The Division will attach an invoice for the base DIME fee to the DIME physician confirmation issued pursuant to section 11-4(A)(6). The selected DIME physician shall receive the fee from the paying party prior to scheduling the examination unless the claimant has filed an indigent application pursuant to section 11-12. If such an application is filed the paying party shall submit the DIME fee within fourteen (14) days of the order on that application or within fourteen (14) days of the final DIME physician selection, whichever is later.

(C) The paying or requesting party shall, no later than fourteen (14) days prior to the scheduled examination, (1) submit payment for the additional record review fees to the DIME physician or (2) request a prehearing conference and notify via electronic mail all parties, the confirmed DIME physician, and the DIME Unit.

(1) The prehearing conference will be limited to disputes as to whether the medical records are (a) regarding the diagnosis, treatment, and evaluation of the claimant's work-related injury(ies) or disease(s), as well as relevant pre-existing condition(s), injury(ies), or disease(s); or (b) duplicative.

(2) No rescheduling or termination fees otherwise applicable under subsection (D) of this rule are payable if the rescheduling or termination was due solely to the payment of additional record review fees.

(D) Prior to the examination, the DIME may only be rescheduled by the requesting party or by order. The party responsible for the rescheduling (or the paying party when the indigent claimant is responsible for the rescheduling) shall submit the rescheduling fee, if applicable, to the DIME physician within ten (10) days of the defaulting event. The requesting party shall reschedule the appointment after the physician receives this fee. Rescheduling of the DIME more than once requires a finding of good cause by an ALJ. The DIME rescheduling and termination fees shall be as follows (unless reduced by an ALJ upon a showing of good cause):

(1) Rescheduling fees:

	DIME is rescheduled more than ten (10) days before the scheduled date	DIME is rescheduled ten (10) days or less before the scheduled date	DIME is rescheduled one (1) business day or less prior to the scheduled date
$1,000 DIME	No fee	$500	$1,000
$1,400 DIME	No fee	$700	$1,400
$2,000 DIME	No fee	$1,000	$2,000

(2) Termination fees:

	DIME is terminated more than ten (10) days before the scheduled date	DIME is terminated ten (10) days or less before the scheduled date	DIME is terminated one (1) business day or less prior to the scheduled date
$1,000 DIME	$250	$500	$1,000
$1,400 DIME	$350	$700	$1,400
$2,000 DIME	$500	$1,000	$2,000

(3) The rescheduling and termination fees shall apply to the agreed-upon DIMEs under section 11-4(A)(2)(a)(i). The fees shall be determined based on the section 11-5(A)(1) – (3) category that would have applied.

(4) If the DIME physician reschedules the examination more than two (2) times, the physician shall pay $250.00 fee to the paying party.

(5) The DIME physician shall refund the DIME fee minus the termination fee to the paying party within ten (10) days of receiving the notice of termination.

(6) The parties and the DIME physician may use the Notice of Reschedule or Termination form to notify the DIME Unit of any rescheduling, termination, or failure to attend the DIME.

(E) It is expected that a test essential for an impairment rating to be rendered under the AMA Guides, 3rd Edition (revised) or the Level II accreditation curriculum will have been performed prior to the DIME. Routine tests necessary for a complete DIME should be performed as part of the DIME with no additional cost. If an essential test is non-routine or requires special facilities or equipment, and such test was not previously performed, or was previously performed but the findings are not usable at the time of the DIME, the DIME physician shall notify the DIME Unit, who will notify the parties. The DIME physician will either perform the essential test or refer out the essential test for completion at the insurer's expense unless extraordinary circumstances are determined by an ALJ. A return visit for range of motion validation shall be considered a part of the initial DIME.

(F) Services rendered by a DIME physician shall conclude upon acceptance by the Division of the final DIME report.

(G) A party who seeks the presence of a DIME physician as a witness at a proceeding for any purpose, by subpoena or otherwise, shall pay the physician.

11-6 COMMUNICATION WITH A DIME PHYSICIAN

(A) During the DIME process, there shall be no communication between the parties and the DIME physician except in circumstances allowed under section 11-3(F). The parties shall provide the DIME Unit with copies of any permitted correspondence with the DIME physician. Any violation may result in termination of the DIME.

(B) After acceptance by the Division of the final DIME report, no communication with the DIME physician shall be allowed by any party or their representative except under the following circumstances: approval by the Director; by written agreement of all parties; by an order of an ALJ; or by deposition or subpoena. The parties shall provide the Division with copies of any correspondence with the DIME physician permitted under this section.

11-7 DIME FOLLOW-UP

(A) If a DIME physician determines that a claimant has not reached MMI and recommends additional treatment, a follow-up DIME examination shall be scheduled with the same DIME physician, unless the physician is unavailable or declines to perform the examination. Either party may file the Follow-Up DIME form after the claimant completes all additional recommended treatment.

(B) The parties shall indicate on the Follow-Up DIME form if the previous DIME physician is unavailable or declines to perform the follow-up DIME. In that case, the parties also shall indicate whether they have agreed on the new physician and a follow-up fee.

(1) If the parties have agreed on the new DIME physician, the parties also must agree on a follow-up fee. The parties shall indicate the fee on the Follow-Up DIME form. The form shall be signed by the new DIME physician and all parties to the claim.

(2) If the parties have not agreed on the new DIME physician and the follow-up fee, the following procedures shall apply:

(a) If previous DIME physician was selected pursuant to the procedures set forth in section 11-4(A)(5), the Division shall provide one replacement name to the previous list of three physicians and present that revised list to the parties where each shall strike one name according to the procedures set forth in that section.

(b) If the parties have agreed on the previous DIME physician under section 11-4(A)(2)(a)(i) but now wish to proceed under section 11-4(A)(5), the parties shall request a prehearing conference before an ALJ.

(C) Either party shall notify in writing the DIME Unit and the other party of the date and time of the follow-up DIME.

(D) Absent an agreement of the parties and the DIME physician, or an order from an ALJ, the insurer shall pay any additional examination fees. The physician must receive the follow-up examination fee prior to scheduling the examination.

(1) Follow-up fees where the exam is scheduled with the original DIME physician shall be as follows:

Filing date of the Follow-Up DIME form	Follow-up evaluation fee
3 months or less after the last evaluation	$350
Over 3 months but 6 months or less after the last evaluation	$700
Over 6 months but 12 months or less after the last evaluation	$1,000
Over 12 months after the last evaluation	$1,400

(2) Follow-up fees where the exam is scheduled with a new DIME physician shall be as follows:

Filing date of the Follow-Up DIME form	Follow-up evaluation fee
Less than five years from the date of injury to the Follow-Up DIME form	$1,400
Five years or more from the date of injury to the Follow-Up DIME form	$2,000

Additional record review fees and procedures set forth in sections 11-5(A)(4) and (C) will apply to follow-up exams scheduled with a new DIME physician, if the medical records for a $1,400 follow-up dime exceed 750 pages, or if the medical records for a $2,000 follow-up DIME exceed 1,000 pages.

(E) If the follow-up DIME is rescheduled the party responsible for the rescheduling (or the paying party when the indigent claimant is responsible for the rescheduling) shall submit the required fee, if applicable, to the DIME physician within ten (10) days of the defaulting event. The requesting party shall reschedule after the physician receives this fee. Rescheduling of the DIME more than once requires a finding of good cause by an ALJ.

(1) Rescheduling fees for a follow-up examination shall be as follows:

	DIME is rescheduled more than ten (10) days before scheduled date	DIME is rescheduled ten (10) days or less before the scheduled date	DIME is rescheduled one (1) business day or less before scheduled date
$350 Follow-up DIME	No fee	$350	$350
$700 Follow-up DIME	No fee	$700	$700
$1,000 Follow-up DIME	No fee	$700	$1,000
$1,400 Follow-up DIME	No fee	$700	$1,400
$2,000 Follow-up DIME	No fee	$1,000	$2,000

(2) Termination fees for a follow-up examination shall be as follows:

	DIME is terminated more than ten (10) days before the scheduled date	DIME is terminated ten (10) days or less before the scheduled date	DIME is terminated one (1) business day or less prior to the scheduled date
$350 Follow-up DIME	$350	$350	$350
$700 Follow-up DIME	$350	$700	$700
$1,000 Follow-up DIME	$350	$700	$1,000
$1,400 Follow-up DIME	$350	$700	$1,400
$2,000 Follow-up DIME	$350	$1,000	$2,000

(3) The rescheduling and termination fees shall apply to the agreed-upon follow-up DIMEs under section 11-7(B). The fees shall be determined based on the section 11-7(D) category that would have applied.

(F) If the DIME physician reschedules the follow-up examination more than two (2) times, the physician shall pay $250.00 fee to the paying party.

(G) The DIME physician shall refund the follow-up examination fee minus the termination fee to the paying party within ten (10) days of receiving the notice of termination.

(H) The parties and the DIME physician may use the Notice of Reschedule or Termination form to notify the DIME Unit of any rescheduling, termination, or failure to attend the follow-up examination.

(I) For follow-up exams scheduled with the original DIME physician, the parties shall submit additional medical records in accordance with section 11-4(B). For follow-up exams scheduled with a new DIME physician, the parties shall submit the entire medical records packet in accordance with section 11-4(B).

11-8 DIMES FOLLOWING REOPENING

DIMEs performed in claims that have been reopened pursuant to §8-43-303 are considered subsequent DIMEs and will be treated as new DIMEs subject to all DIME procedures in this rule. The party requesting the subsequent DIME shall be considered the requesting party regardless of whether that party requested the original DIME. By filing the application form in a claim where a DIME has been completed previously, the requesting party certifies the claim has been reopened pursuant to §8-43-303.

11-9 REMOVAL OF A PHYSICIAN FROM THE SELECTION PROCESS

(A) Complaints regarding a DIME physician may be submitted to the Director or the Medical Director. The Director may temporarily inactivate and exclude a physician from the revolving selection process.

(B) The Director, in consultation with the Medical Director, may permanently remove a physician from the medical review panel on any of the following grounds:

(1) A misrepresentation on the application for appointment;

(2) Refusal and/or substantial failure to comply or two or more incidents of failure to comply with the provisions of The Act, the Workers' Compensation Rules of Procedure and/or any other relevant statutes;

(3) Loss or suspension of Level I and/or Level II accreditation;

(4) For good cause as determined by the Director.

(C) A physician removed under this section may apply to the Director for reinstatement after six months. The reinstatement decision is at the sole discretion of the Director.

11-10 IMMUNITY

Doctors and other individuals involved in the DIME process who have acted within the appropriate scope of their capacity shall be immune from liability in any civil action for any actions undertaken in good faith and in the reasonable belief that the actions were appropriate under the circumstances.

11-11 DISPUTES

Non-compliance with this rule may be addressed through the Dispute Resolution process described in Rule 16 or through any other mechanism of dispute resolution provided for in rule or statute.

11-12 INDIGENCE PROCESS

(A) Within 15 days of filing the Notice and Proposal and Application for a Division Independent Medical Examination form, a claimant asserting indigent status shall file an "Application for Indigent Determination (DIME)" form at the Office of Administrative Courts with copies to the other parties and the DIME Unit.

(B) The DIME process will not be held in abeyance while the indigent application is pending unless so ordered by an ALJ.

(C) Within eight (8) days after the date of mailing of the Application for Indigent Determination (DIME) form, any other party to the claim may file a response at the Office of Administrative Courts. Any such response shall state with specificity the grounds for objection.

(D) An ALJ shall issue a written order to all parties within twenty (20) days after the application is filed, a hearing will only be held if a timely submitted response raises disputed questions of material fact or if there is a lack of sufficient information in the written submissions of the parties. Any such hearing shall be held as soon as possible and a ruling shall be issued within thirty (30) days of the date of filing of the indigent application.

(E) The determination regarding indigence shall be based on the claimant's financial status on the date the application is filed and any extraordinary circumstances. In ruling on the application, the ALJ shall apply the standards set forth in Rule 11-13. Extraordinary circumstances exist where the claimant would be deprived of the ability to provide for basic necessities that cannot be deferred, such as food, shelter, clothing, utilities and out of pocket medical costs.

(F) The insurer or self-insured employer shall advance the costs of the DIME, including rescheduling, termination, or late records fees on behalf of the indigent claimant. These costs shall be taken as an offset against permanent indemnity benefits following either a final order or approved settlement.

11-13 INDIGENCE STANDARDS

(A) A person shall be found to be indigent for purposes of rule 11-12 only if:

(1) income is at or below eligibility guidelines; or

(2) "extraordinary circumstances" exist which merit a determination of indigence.

(B) Income eligibility guidelines:

FAMILY SIZE	MONTHLY INCOME GUIDELINES
1	$2,832
2	$3,814
3	$4,798
4	$5,782
5	$6,764
6	$7,748
7	$8,732
8	$9,714

*For family units with more than eight members, add $984 per month for "monthly income" or $11,800, per year for "yearly income" for each additional family member.

(1) Income is gross income from all members of the household who contribute monetarily to the common support of the household.

Rule 12 Permanent Impairment Rating Guidelines

12-1 STATEMENT OF PURPOSE

Pursuant to §8-42-101(3.5)(a)(II), C.R.S., all permanent impairment ratings shall be based upon the *American Medical Association Guides to the Evaluation of Permanent Impairment*, Third Edition (Revised), in effect as of July 1, 1991, (AMA Guides). This rule implements the Division's permanent impairment rating guidelines on how to appropriately utilize and report permanent impairment ratings.

12-2 PROVIDER RESPONSIBILITIES

(A) Where the authorized treating physician has determined that the injured worker is at maximum medical improvement (MMI) and has not returned to his/her pre-injury state, physically and/or mentally, the treating physician shall determine or cause to be determined a permanent medical impairment rating in accordance with this Rule 12.

(B) Any Level II accredited physician determining permanent impairment shall rate in accordance with their administrative, legal and medical roles as established by Level II accreditation.

12-3 APPORTIONMENT

(A) For claims with a date of injury prior to July 1, 2008, a Level II accredited physician ("the Physician") shall apportion any preexisting medical impairment, whether work-related or non work-related, from a work-related injury or occupational disease using the AMA Guides, 3rd Edition, Revised, where medical records or other objective evidence substantiate a preexisting impairment to the same body part. Any such apportionment shall be made by subtracting from the injured worker's impairment the preexisting impairment as it existed at the time of the subsequent injury or occupational disease. The physician shall explain in their written report the basis of any apportionment. If there is insufficient information to measure the change accurately, the physician shall not apportion.

(B) For claims with a date of injury on or after July 1, 2008, the Physician may provide an opinion on apportionment for any preexisting work related or non work-related permanent impairment to the same body part using the AMA Guides, 3rd Edition, Revised, where medical records or other objective evidence substantiate a preexisting impairment. Any such apportionment shall be made by subtracting from the injured worker's impairment the preexisting impairment as it existed at the time of the subsequent injury or occupational disease. The Physician shall explain in their written report the basis of any apportionment. If there is insufficient information to measure the change accurately, the Physician shall not apportion. If the Physician apportions based on a prior non work-related impairment, the Physician must provide an opinion as to whether the previous medical impairment was identified, treated and independently disabling at the time of the work-related injury that is being rated. Identified and treated in this context requires facts reflecting that a medical provider previously noted and provided some level of treatment for the non work-related impairment.

(1) The effect of the Physician's apportionment determination is limited to the provisions in section 8-42-104. When filing an admission an insurer shall provide documentation reflecting compliance with section 8-42-104.

(2) If the Physician provides an opinion on the apportionment of medical and temporary disability benefits, the claimant's receipt of medical and temporary disability benefits shall not be reduced based upon any such opinion.

12-4 PERMANENT PHYSICAL IMPAIRMENT RATINGS

Any physician determining permanent physical impairment shall:

(A) Limit such rating to physical impairments not likely to remit despite medical treatment; and

(B) Use the instructions and forms contained in the AMA Guides and,

(C) Convert scheduled impairment rating to whole person impairments.

(D) Report final whole person and/or scheduled impairment rating percentages in whole numbers.

12-5 PERMANENT MENTAL AND BEHAVIORAL DISORDER IMPAIRMENT RATINGS

(A) Any physician determining permanent mental or behavioral disorder impairment shall:

(1) Limit such rating to mental or behavioral disorder impairments not likely to remit despite medical treatment; and

(2) Use the instructions contained in the AMA Guides giving specific attention to:

(a) Chapter 4, "Nervous System"; and

(b) Chapter 14, "Mental and Behavioral Disorders"; and

(3) Complete a full psychiatric assessment following the principles of the AMA Guides, including:

(a) A nationally accepted and validated psychiatric diagnosis made according to established standards of the American Psychiatric Association as contemplated by the AMA Guides; and

(b) Complete history of impairment, associated stressors, treatment, attempts at rehabilitation and premorbid history so that a discussion of causality and apportionment can occur.

(B) If the permanent impairment is due to organic deficits of the brain and results in disturbances of complex integrated cerebral function, emotional disturbance or consciousness disturbance, then Chapter 4, "Nervous System," shall be consulted and, may be used, when appropriate, with Chapter 14, "Mental and Behavioral Disorders." The same permanent impairment shall not be rated in both sections. The purpose is to rate the overall functioning, not each specific diagnosis. Determination of the appropriate chapter(s) is left to the professional judgment of the physician.

(C) The permanent impairment report shall include a written summary of the mental evaluation and the work sheet incorporated herein as part of this rule (Division form WC-M3-PSYCH). The impairment rating shall be established using the "category definition guidelines" set forth in this rule, and which shall supplement the related instructions in the AMA guides. When appropriate, the physician shall address apportionment.

(D) Where other work-related permanent impairment exists, a combined whole-body permanent impairment rating may be determined by the authorized treating physician providing primary care if Level II accredited. Where the authorized treating physician providing primary care is not determining permanent impairment, it shall be determined by the Level II accredited rating physician designated by the authorized treating physician providing primary care.

12-6 PERMANENT IMPAIRMENT RATINGS OF THE EXTREMITIES

(A) The AMA Guides do not provide for permanent impairment ratings specifically for the partial loss of use of the following:

(1) Forearm at the elbow;

(2) Joints at the wrist or ankle;

(3) Leg at the knee; or

(4) Toes at the metatarsal.

The AMA Guides define these as permanent impairments of the:

(1) Entire finger, whole hand, or whole upper extremity; or

(2) Entire toe, whole foot, or whole lower extremity.

(B) When an injury causes the partial loss of use of any member specified in the scheduled injuries, as set forth in §8-42-107(2), C.R.S., the physician shall use the most distal body part. The most distal body part is the body part farthest away from the central body.

(C) In calculating partial loss-of-use benefits, the most distal permanent impairment rating provided by the physician shall be multiplied by the number of weeks corresponding to the scheduled injury for the appropriate entire finger, whole hand, or whole upper extremity, or the appropriate entire toe, whole foot, or whole lower extremity, then multiplied by the amount pursuant to § 8-42-107(6),C.R.S.

12-7 PERMANENT IMPAIRMENT RATINGS FOR CUMULATIVE TRAUMA

(A) The Cumulative Trauma Disorder (CTD) rating system is designed for disorders that primarily involve muscular, tendinous, ligamentous and bony structures. It follows the same general principles set forth in section 3.1j of the AMA Guides and has similar relative values for traumatic soft tissue conditions. Disorders that have vascular or neurologic involvement are rated by other sections of the AMA Guides.

(B) Impairments secondary to Cumulative Trauma Disorders may be accompanied by impairments that are ratable using existing portions of the AMA Guides. The Level II accredited physician shall first calculate any applicable impairment from range of motion, neurologic and/or vascular findings, or other disorders (section 3.1j) excluding grip strength. If no impairment exists under these sections of the AMA Guides and the physician has determined that the claimant has an impairment of daily living activities with anatomic and physiologic correlation, the physician shall proceed to rate the impairment as follows:

(1) Multiple joint and upper extremity sites can be involved in CTD. Limit the impairment determination to areas of primary pathology, with anatomic or physiologic correlation based on objective findings. Do not rate areas of reactive muscular spasm and radiating or referred pain.

(2) Determine the stage of cumulative trauma for each joint involved, Stage 1 is 0-10%, Stage 2 is 11-20%, Stage 3 is 21-30%, and Stage 4 is 31-40%. Refer to Rule 17, Exhibit 2.

(3) Identify the appropriate joint impairment found on Table 17 of Chapter 3 of the AMA Guides.

(4) Multiply the joint impairment from Table 17 by the CTD stage impairment from step B to yield an upper extremity impairment.

(5) If there is anatomic and physiologic basis to rate other joints in the same extremity, complete the rating in the manner described and combine the extremity ratings distal to proximal.

(6) If extremity impairment is bilateral, convert each upper extremity impairment to whole person rating and then combine whole person ratings for both right and left upper extremities as referenced in the AMA Guides. Complete the upper extremity worksheets, Figure 1 of Chapter 3 of the AMA Guides, for each extremity separately.

(C) The CTD rating system is preferred to impairment determined by decrease in grip strength. If grip strength is used, the CTD rating system shall not be used as it would be duplicative. Similarly, care must be taken to avoid duplicative ratings with other associated disorders where there is significant neurovascular involvement or where there is limitation in ranges of motion. For further reference to these cautions, refer to the AMA Guides, section 3.1j.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation

PERMANENT WORK-RELATED MENTAL IMPAIRMENT RATING REPORT WORK SHEET

Since the AMA Guides to the Evaluation of Permanent Impairment, 3rd Edition (Revised) does not provide a quantified method for assigning permanent impairment percentages under Chapter 14, "Mental and Behavioral Disorders," the provider shall utilize this form.

Patient Name _____ Date of Service: _____
WC # _____ Carrier # _____

SCORING INSTRUCTIONS:

1. This form should only be used to determine an impairment after the case has been found to meet all of the specific criteria for a Diagnostic and Statistical Manual (DSM) diagnosis.

2. The AMA Guides to Permanent Impairment, 3rd Edition (Revised) should be consulted for guidance in determining these ratings.

3. Determination of a rating of permanent mental or behavioral impairment shall be limited to mental or behavioral disorder impairments not likely to remit with further mental health treatment.

4. Impairment ratings based on chronic pain are not applicable within the mental/behavioral domain, but are restricted to physical examination with evidence of anatomic or physiologic correlation and included within a physical impairment rating.

5. To obtain the final overall impairment rating:

    a. The elements to be rated are divided into four Areas of Function: Activities of Daily Living; Social Functioning; Thinking, Concentration and Judgment; and Adaptation to Stress.

    b. Assign a rating (0-6) to each subcategory of the areas of function based on patient self-report, other sources of information, and the physician's clinical assessment. (See Category Definitions on page 6 of this form.) Given the heavy reliance on the patient's subjective report for information in some of the ratings, the physician should give careful consideration to any corroborating evidence that might be available.

    c. Average the two highest subcategory ratings within each Area of Function to obtain the overall category rating. For example, if the two highest scores are 2 and 5, the category score is 3.5.

    d. To calculate the overall impairment rating, average the two highest category ratings and then, if appropriate in the case, use clinical judgment to add or subtract up to 0.5 point from the result. If the score is modified in this fashion due to clinical judgment, ***justification for doing so must be documented***. Factors influencing the physician's discretion may include the following:

        i. Factors influencing the patient's believability, such as the presence of symptom magnification, or the presence or absence of corroborating information from psychological or neuropsychological testing;

        ii. The extent to which medication ameliorates the effects of the condition;

e. Use the Category Conversion Table in these instructions to convert the final number to a percentage.

6. Include the DSM diagnosis at the top of the worksheet.

The final determination must include ratings for all of the elements in each area of function, the category averages reached in each area of function, the overall average, the final assigned overall permanent impairment rating, and documentation for any divergence (±0.5) from the calculated score.

CATEGORY CONVERSION TABLE	
Final Score	**Percentage**
0	0
0.25	0
0.5	1
0.75	1
1	**1**
1.25	2
1.5	3 to 4
1.75	5
2	**6 to 7**
2.25	8 to 9
2.5	10 to 12
2.75	13 to 15
3	**16 to 18**
3.25	19 to 21
3.5	22 to 23
3.75	24 to 25
4	**26 to 32**
4.25	33 to 38
4.5	39 to 44
4.75	45 to 50
5	**51 to 56**
5.25	57 to 62
5.5	63 to 68
5.75	69 to 75
6	**76 to 83**
6.25	84 to 91
6.5	92 to 100

7. If apportionment is applicable, complete a separate form calculating the pre-injury rating to be subtracted from the total current rating.

8. If there is a finding of no impairment, refer to Part V on the worksheet, if appropriate.

WORKSHEET

Patient Name _____ Date of Service: _____
WC # _____ Carrier # _____

NOTE: Determination of a rating of permanent mental or behavioral impairment shall be limited to mental or behavioral disorder impairments not likely to remit with further mental health treatment. Further, impairment ratings based on chronic pain are not applicable within the mental/behavioral domain, but are restricted to physical examination with evidence of anatomic or physiologic correlation and included within a physical impairment rating.

I. DSM Diagnosis: Axis I:_____ Axis II:_____

II. LEVELS OF PERMANENT MENTAL IMPAIRMENT

Category

0. No permanent impairment
1. Minimal Category of Permanent Impairment
2. Mild Category of Permanent Impairment
3. Moderate Category of Permanent Impairment
4. Marked Category of Permanent Impairment
5. Extreme Category of Permanent Impairment
6. Maximum Category of Permanent Impairment

III. AREAS OF FUNCTION[1]

1. Activities of Daily Living. ***Rate only impairments due strictly to the psychiatric condition.***

0 1 2 3 4 5 6 Self care and hygiene (dressing, bathing, eating, cooking)
0 1 2 3 4 5 6 Travel (driving, riding, flying) i.e. impairments in driving, riding, flying which are generally a result of symptoms of affective or anxiety disorders
0 1 2 3 4 Sexual function (participating in usual sexual activities)
0 1 2 3 4 Sleep (restful sleep pattern)

Overall Category Rating:
(average of 2 highest)
_____

2. Social Functioning

0 1 2 3 4 5 6 Interpersonal relationships
0 1 2 3 4 5 6 Communicates effectively with others
0 1 2 3 4 5 6 Participation in recreational activities (consider pre-injury activities of the patient)
0 1 2 3 4 5 6 Manage conflicts with others--negotiate, compromise

Overall Category Rating:
(average of 2 highest)
_____

[1]See attached Appendix for further description of all or part of the listed areas of function.

3. Thinking, Concentration & Judgment

0 1 2 3 4 5 6 Ability to perform complex or varied tasks
0 1 2 3 4 5 6 Judgment
0 1 2 3 4 5 6 Problem solving
0 1 2 3 4 5 6 Ability to abstract or understand concepts
0 1 2 3 4 5 6 Memory, immediate and remote
0 1 2 3 4 5 6 Maintain attention, concentration on a specific task
0 1 2 3 4 5 6 Perform simple, routine, repetitive tasks
0 1 2 3 4 5 6 Comprehend/follow simple instructions

Overall Category Rating:
(average of 2 highest)

_____

4. Adaptation to Stress

0 1 2 3 4 5 6 Set realistic short & long term goals
0 1 2 3 4 5 6 Perform activities (including work) on schedule
0 1 2 3 4 5 6 Adapt to job performance requirements

Overall Category Rating:
(average of 2 highest)

_____

IV. FINAL CALCULATIONS:

Average the two highest Area of Function ratings: ___ + ___ **divided by 2 =** _____

Add or subtract up to 0.5 from the completed calculation above, if appropriate, based on clinical judgment.
Justify this deviation below or attach a separate sheet: _____

Using the Category Conversion Table on page 2 of this form, convert the final number to a percentage for the overall permanent impairment rating:

Overall Psychiatric Permanent Impairment Rating _____%

OR

V. If this patient has ZERO impairment according to the above criteria and requires continuing medication for their DSM diagnosis, an impairment of 1-3% may be assigned _____%.

IF ZERO % PSYCHIATRIC RATING RATING_____%

VI. TOTAL IMPAIRMENT RATING (if applicable)
Total Whole Person *Physical* Impairment = _____%

Combined with psychiatric permanent impairment equals:

Total Whole Person Impairment (including psychiatric impairment) _____%

Physician: _____ Date: _____
(Signature)

APPENDIX

1. Activities of Daily Living

Sexual Function: Scoring categories 5 and 6 are not available because the maximum impairment allowed per the AMA Guides for total loss of sexual function is 30% for a male less than 40 years of age; 20% for a male 40 or older.

Sleep: Scoring categories 5 and 6 are not available because the AMA Guides allow a maximum of 50% impairment for sleep or arousal disorders. To reach a 20% rating the activities of daily living must be affected to the extent that supervision is required in some areas. To reach a 50% rating, supervision by caretakers is required.

2. Social Functioning

Social functioning refers to an individual's capacity to interact appropriately and communicate effectively with other individuals. Social functioning includes the ability to get along with others, such as with family members, friends, neighbors, grocery clerks, landlords or bus drivers. Impaired social functioning may be demonstrated by a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, social isolation, etc. Strength in social functioning may be documented by an individual's ability to initiate social contacts with others, communicate clearly with others, interact and participate in group activities, etc. Cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity also need to be considered. Social functioning in work situations may involve interactions with the public, responding appropriately to persons in authority, such as supervisors, or cooperative behaviors involving co-workers.

Again, it is not the number of areas in which social functioning is impaired, but the overall degree of interference with a particular functional area or combination of such areas of functioning. For example, a person who is highly antagonistic, uncooperative, or hostile, but is tolerated by local storekeepers may nevertheless have marked restrictions in social functioning because that behavior is not acceptable in other social contexts, such as work. (*AMA Guides, 3rd Edition (revised),* p. 237)

3. Thinking, Concentration and Judgment

Thinking, concentration, and judgment refer to the ability to sustain focused attention sufficiently long to permit the timely completion of tasks and to make reasoned or logical decisions as to alternative courses of action. Deficiencies in concentration and judgment are best observed in work and work-like settings. Major impairment in this area can often be assessed through direct psychiatric examination and/or psychological testing, although mental status examination or psychological test data alone should not be used to accurately describe concentration and sustained ability to perform work-like tasks. On mental status examinations, concentration is assessed by tasks requiring short-term memory or through tasks such as having the individual subtract serial sevens from 100. In psychological tests of intelligence or memory, concentration can be assessed through tasks requiring short-term memory or through tasks that must be completed within established time limits. Strengths and weaknesses in areas of concentration can be discussed in terms of frequency of errors, time it takes to complete the task, and extent to which assistance is required to complete the task. (*Disability Evaluation Under Social Security*, p.88, Social Security Administration Pub. No. 64-039)

4. Adaptation to Stress

The individual should be able to set realistic and appropriate goals. Given that the work-related injury may have induced various limitations, the individual should demonstrate realistic adaptations to the medical/physical situation. He/she should be able to accommodate changes from pre-injury status to the current status. Adapting to performance standards requires that the individual can adequately cope with job performance and time expectations. Further, the individual should demonstrate the capacity to follow rules and policies, respond appropriately to changes in the work setting, and utilize resources available within the community, medical and family areas.

PERMANENT WORK-RELATED MENTAL IMPAIRMENT RATING
REPORT WORK SHEET
CATEGORY DEFINITION GUIDELINES

CATEGORY 0: - **No Permanent Impairment.**

Mental symptoms arising from the work-related psychiatric diagnosis have been absent for the past month. ADLs are not affected. Functioning is at pre-injury baseline in social and work activities in all areas; no more than everyday problems.

CATEGORY 1: **Minimal Category of Permanent Impairment.**

Mental symptoms, arising from the work-related psychiatric diagnosis and not likely to remit despite medical treatment, minimally impair functioning.

CATEGORY 2: **Mild Category of Permanent Impairment.**

Mental symptoms, arising from the work-related psychiatric diagnosis are not likely to remit despite medical treatment, and are mildly impairing. ADLs are mildly disrupted. Functioning shows mild permanent impairment in social or work activities.

CATEGORY 3: **Moderate Category of Permanent Impairment.**

Mental symptoms, arising from the work-related psychiatric diagnosis and not likely to remit despite medical treatment, are moderately impairing. ADLs are moderately disrupted. Functioning shows moderate permanent impairment. Activities sometimes need direction or supervision.

CATEGORY 4: **Marked Category of Permanent Impairment**.

Mental symptoms, arising from the work-related psychiatric diagnosis and not likely to remit despite medical treatment, are seriously impairing. ADLs are seriously disrupted. Functioning shows serious difficulties in social or work activities.

CATEGORY 5: **Extreme Category of Permanent Impairment.**

Mental symptoms, arising from the work-related psychiatric diagnosis and not likely to remit despite medical treatment, are incapacitating. At times, ADLs require structuring. Functioning is quite poor, unsafe in work settings, at times requires hospitalization or full-time supervision. Most activities require directed care.

CATEGORY 6: **Maximum Category of Permanent Impairment.**

This impairment level precludes useful functioning in all areas. These individuals are generally appropriate for institutionalized settings, if available. All activities require directed care.

Rule 13 Provider Accreditation

13-1 STATEMENT OF BASIS AND PURPOSE

(A) This rule implements and establishes procedures for the provider accreditation program set forth in § 8-42-101(3.5) and (3.6), C.R.S., as well educates the providers about their administrative, legal, and medical roles in the Colorado workers' compensation system. Accreditation requirements shall apply to:

(1) Providers who seek Level I or Level II accreditation under § 8-42-101(3.5) and (3.6), C.R.S.;

(2) Physicians providing permanent impairment evaluations of claimants; and

(3) Physicians serving on the Division Independent Medical Examination Panel.

13-2 ACCREDITATION

(A) To obtain Level I Accreditation, a provider must:

(1) Qualify under § 8-42-101(3.5), C.R.S.;

(2) Complete an application form prescribed by the Division and pay the registration fee;

(3) Complete the Division Level I course;

(4) Demonstrate an understanding of the Division materials by passing a Division-administered examination. If the provider does not exhibit sufficient knowledge upon taking the examination a second time, he or she must attend the seminar again prior to any further attempts at the examination. Additional fees may apply.

(5) Agree to comply with all relevant statutes, Division rules, and all Division-issued guidance (including materials incorporated by reference);

(6) The accreditation begins on the date the provider passes the examination. The accreditation expires on July 31st of the third year following the year the provider passed the examination.

(B) To obtain Level II Accreditation, a physician must:

(1) Receive Level I accreditation. However, a physician who received his/her initial Level II accreditation before January 1, 2018 is exempt from this requirement.

(2) Qualify under § 8-42-101(3.5), C.R.S.;

(3) Complete an application form prescribed by the Division, pay the registration fee, and indicate if full or limited accreditation is sought;

(4) Complete the Division Level II course;

(5) Demonstrate an understanding of the Division materials (including the American Medical Association Guides to the Evaluation of Permanent Impairment, as incorporated by reference into § 8-42-101(3)(a)(I), C.R.S. ('AMA Guides')) by passing a Division-administered examination. If the provider does not exhibit sufficient knowledge upon taking the examination a second time, he or she must attend the seminar again prior to any further attempts at the examination. Additional fees may apply.

(i) Full Accreditation: A physician who passes the full Level II Accreditation examination shall be fully accredited to determine permanent impairment ratings on any work-related injury or illness.

(ii) Limited Accreditation: A physician who seeks Level II Accreditation to rate impairment only in connection with a specialty medical practice and who satisfactorily completes specified portions of the Level II examination shall receive limited accreditation to determine permanent impairment ratings on the corresponding sections of the AMA Guides.

(6) Agree to comply with all relevant statutes, Division rules, and all Division-issued guidance (including materials incorporated by reference).

(7) Submit his/her first three (3) impairment rating reports deemed sufficient by the Division within 12 months of passing the Level II accreditation examination; and

(8) Agree to the probationary one-year Level II accreditation period beginning on the date the physician passes the Level II accreditation examination. The probationary accreditation will expire if the physician fails to submit three (3) impairment rating reports deemed sufficient by the Division within one year of the examination. Non-probationary accreditation begins on the date the physician submits his/her first three (3) impairment rating reports deemed sufficient by the Division. The non-probationary accreditation expires on January 31ST of the third calendar year following the year the physician successfully completed the Level II Accreditation examination.

13-3 RENEWAL OF ACCREDITATION

(A) The Division will attempt to notify accredited providers of impending expiration of their accreditation.

(B) A provider who does not renew his or her accreditation before the expiration date may reapply and complete the process for initial accreditation under section 13-2.

(C) To renew accreditation, a provider must:

(1) Qualify under § 8-42-101(3.5), C.R.S.;

(2) Complete an application form prescribed by the Division, pay the registration fee, and, for Level II accreditation, indicate if full or limited reaccreditation is sought;

(3) Complete the Division course requirements for the highest level of accreditation maintained;

(4) Agree to comply with all relevant statutes and Division rules; and

(5) For Level II reaccreditation only, submit one impairment rating report deemed sufficient by the Division (which may be a Division Independent Medical Examination report) for audit. The purpose of providing an impairment report is to demonstrate an understanding of the requirements of a sufficient impairment rating report; to educate and provide feedback to the physician; and to assist the Division in examining its curriculum. Any correspondence or communication regarding this process is confidential and shall not be subject to discovery or examination by any person.

13-4 SANCTIONS UPON ACCREDITATION

(A) The Director, with input from the Medical Director, may initiate proceedings to sanction a Level I or Level II Accreditation on any of the following grounds:

(1) Refusal to comply, substantial failure to comply, or two or more incidents of failure to comply with the provisions of these Workers' Compensation Rules of Procedure and all relevant statutes.

(2) Misrepresentation on the application for accreditation, or

(3) A unanimous recommendation to revoke accreditation by a reviewing panel pursuant to § 8-43-501(3)(c)(III) and (4), C.R.S..

(B) The severity of any sanctions taken under these rules shall reflect the character of the failure and the attendant circumstances. Examples of sanctions include, but are not limited to, a suspension or a revocation of accreditation.

(C) A proceeding to sanction a Level I or Level II Accreditation may be initiated by the Director, with input from the Medical Director, with referral for a hearing before an administrative law judge.

(D) Following a hearing, the administrative law judge shall render proposed findings of fact and conclusions of law, and make recommendations to the Director, who shall enter an order in the case.

Rule 14 Applications For Admission And Payment Of Benefits From The Major Medical Insurance Fund, The Medical Disaster Fund And Request For Benefits From The Subsequent Injury Fund

14-1 APPLICATIONS FOR ADMISSION TO THE MAJOR MEDICAL INSURANCE FUND AND MEDICAL DISASTER FUND

(A) All applications for admission shall be filed with the Division on the prescribed form along with copies of the payment history, orders, medical records and all available relevant documents that support the application for admission. Upon receipt of an application, the Director shall examine the claim file to determine whether the insurer has exhausted its $20,000 limit of liability for medical benefits as provided in §8-49-101 C.R.S, 1973. Those applications not meeting this requirement shall be dismissed and the applicant will be so notified by the Director.

(B) Applications meeting the above requirement shall be examined by the Director in accordance with the relevant provisions of the act. The Director may approve or disapprove an application for admission to/from the fund without conducting a hearing.

14-2 APPEAL OF ORDER DENYING ADMISSION OR DENYING BENEFITS TO THE MAJOR MEDICAL INSURANCE FUND AND MEDICAL DISASTER FUND

(A) A party who is dissatisfied with an order dismissing or denying an application for admission or dissatisfied with a written denial of benefits may apply for a hearing with the Office of Administrative Courts within 30 days from the date of the order.

(B) When a hearing is requested after a dismissal or denial of an application for admission or for a denial of benefits from the fund, the Director shall be listed as a party and served with all notices, pleadings, reports, and other documents. Where an attorney has entered an appearance for the Director in a case, such service shall be made upon that attorney.

14-3 TERMINATING BENEFITS FROM THE MAJOR MEDICAL INSURANCE FUND

(A) When a party believes that further expenditures from the Major Medical Insurance Fund will not promote recovery, alleviate pain or reduce disability, that party, may file a request with the Director to issue an order to show cause why the Director should not issue a final order to cease payments from the Major Medical Insurance Fund.

(B) Upon the discretion of the Director, an order to show cause why the claim should not be closed from the Major Medical Insurance Fund will be issued. If no response is filed to the order to show cause within 30 days the Director shall issue an order to cease payments from the Major Medical Insurance Fund. If a response to the order to show cause is received within 30 days, the Director shall determine if an order to cease payments shall be issued.

(C) If an order to cease payment is issued, and no objection is filed within 30 days of the order to cease payment, the case shall automatically be closed for payment of benefits from the Major Medical Insurance Fund.

(D) If an objection is timely filed to the order to cease payment the objecting party shall set the case for hearing within 30 days of the date of the objection by filing an application for hearing with the Office of Administrative Courts. The Major Medical Insurance Fund shall continue medical benefits until an application is filed and the matter is resolved by order.

14-4 OFFSET OF LIABILITY TO SUBSEQUENT INJURY FUND FOR ACCIDENTS THAT OCCURRED PRIOR TO 7-1-93 AND OCCUPATIONAL DISEASES THAT OCCURRED PRIOR TO 4-1-94

(A) Offset of liability to the Subsequent Injury Fund, shall be initiated by filing a request for offset with the Division upon the prescribed form and serving the Director with a copy of the request for offset. The party filing the request for offset with the Director shall also simultaneously file with the Director a copy of medical reports, orders and all available relevant documents that support the request for offset.

(B) A request pursuant to §8-46-101, C.R.S., shall list, to the extent available by the requesting party, all prior or pending workers' compensation cases by name and number, a brief description of each injury and the award in each case.

(C) A request pursuant to §8-41-304(2), C.R.S., shall indicate the types of exposures alleged, the approximate dates of each exposure, and the location and the name of the employer in whose employ each exposure allegedly occurred.

(D) A request for offset shall be filed no later than the date the party requesting offset files an application for hearing or response to application for hearing, unless an administrative law judge rules that good cause has been shown for filing later. However, in no event shall a request for offset be filed after a determination, by admission or order, that a claimant is permanently and totally disabled under §8-46-101 or disabled under §8-41-304(2).

(E) The party requesting offset shall also file a proposed order with the Office of Administrative Courts joining the Director as a party on behalf of the Subsequent Injury Fund. Sufficient copies of the order and pre-addressed envelopes for all parties shall also be filed.

(F) The administrative law judge shall consider the proposed order to join the Director and response and rule on whether to join the Director as a party. The ruling shall be based on whether the procedural requirements of this Rule 14 have been met and whether the request states a sufficient basis upon which offset could be granted. Until the Director is joined, notices and orders are not binding on the Subsequent Injury Fund.

(G) When the Director is joined as a party and when an attorney has entered an appearance on behalf of the Subsequent Injury Fund, copies of all reports, pleadings or other documents thereafter filed by any party shall be served upon that attorney.

14-5 STATUS OF DIRECTOR ON BEHALF OF THE SUBSEQUENT INJURY FUND, IN FATAL CASES

(A) The Director shall be deemed to be an interested party in all fatal cases and shall be served with all pleadings, notices, reports, and documents as required for any party. Where an attorney has entered an appearance for the Director in a case, such service shall be made upon that attorney.

(B) In the event a compensable injury results in a death which has not been reported to the Division, the Director may initiate a claim for the death benefits provided by statute.

Rule 15 Vocational Rehabilitation Rules Applicable to Claims based upon an Injury or Illness Occurring prior to July 2, 1987 at 4:16 p.m.

15-1 STATEMENT OF BASIS AND PURPOSE

The rules of procedure governing the vocational rehabilitation component of worker's compensation as originally promulgated pursuant to §8-49-101(4), C.R.S 1973 (repealed 1987) provide a qualified worker an opportunity to re-enter the workforce by establishing guidelines for vocational rehabilitation.

15-2 DEFINITIONS

In addition to the definitions already adopted in the rules, the following definitions apply to vocational rehabilitation procedures:

(A) "Job Modification" is the adaptation of a job either through the use of aids or devices or the alteration of the physical environment of the job, or both, to allow an impaired individual to perform within the scope of tasks originally designed for the job flow.

(B) "Qualified Worker" means a claimant who because of the effects of a work-related injury or occupational disease, (a) is permanently precluded from engaging in his/her usual and customary occupation and is unable to perform work for which the individual has previous training or experience, and (b) can reasonably be expected to attain suitable, gainful employment upon successful completion of a vocational rehabilitation program.

(C) "Qualified Rehabilitation Consultant" means a person authorized by a rehabilitation vendor to conduct a vocational evaluation and develop a rehabilitation plan for a qualified worker.

(D) "Rehabilitation Vendor" means an individual, firm or facility which exists to provide any or all of the services necessary to determine a claimant's eligibility as a qualified worker, and/or provide those services designed to return an individual to work.

(E) "Suitable Gainful Employment" means employment which is reasonably attainable and which offers an opportunity to restore the qualified worker as soon as possible and as nearly as possible to employment with the claimant's qualifications, including but not limited to the claimant's age, education, previous work history, interests and skills. Special consideration shall also be given to the economic level of the claimant at the time of injury and to the present and future labor markets, to attempt to restore him/her to the maximum level attainable.

(F) "Transferable Skills" means those skills an individual possesses which were attained through previous training or experience and are readily marketable and a need for them exists in the current labor market and would provide suitable gainful employment.

(G) "Vocational Evaluation" means the rehabilitation services and testing required by the Director to determine a claimant's eligibility as a qualified worker.

(H) "Vocational Rehabilitation Plan" means a written document completed and signed by a qualified rehabilitation consultant which describes the manner and means by which it is proposed that a qualified worker may be returned to suitable gainful employment through the participation in a rehabilitation program.

(I) "Vocational Rehabilitation Program" means the actual providing of services as prescribed in the vocational rehabilitation plan and approved by the Director as reasonably necessary to restore a qualified worker to suitable gainful employment.

15-3 INITIATION OF VOCATIONAL EVALUATION AND DIRECTOR'S DETERMINATION OF ELIGIBILITY

(A) A vocational evaluation shall be provided by a rehabilitation vendor designated by the insurer, or upon failure of such designation, by the Division in consultation with the claimant, immediately upon knowledge that a claimant is unlikely to be able to return to his/her usual and customary occupation on a permanent basis as determined by competent medical evidence and opinion.

(B) A vocational evaluation summary report shall be submitted to the Director on a form prescribed by the Director and shall include the minimum elements listed on the form. The Director may request additional information necessary to determine eligibility.

(C) The vocational evaluation summary report shall be signed by a qualified rehabilitation consultant responsible for the evaluation and shall contain a recommendation by the consultant whether the claimant is eligible for a vocational rehabilitation program. If the recommendation indicates the claimant is in need of vocational rehabilitation and would benefit from vocational rehabilitation, the summary shall include a description of suggested occupation(s) that would be considered for plan development.

(D) A vocational evaluation shall be completed within sixty (60) days of assignment to the rehabilitation vendor.

(E) Upon submission of the vocational evaluation summary report, the insurer shall indicate whether it is providing vocational rehabilitation voluntarily or is requesting that the Director determine eligibility. Upon a request to determine eligibility the Director shall issue a "Notice of Determination of Eligibility for Vocational Rehabilitation Benefits" within twenty days.

(F) A party may object to the determination of eligibility by filing an application for hearing with the Office of Administrative Courts within fifteen (15) days of the date of the Director's determination.

15-4 SUBMISSION AND IMPLEMENTATION OF THE VOCATIONAL REHABILITATION PLAN

(A) If the claimant is determined a qualified worker, the Director shall order that a vocational rehabilitation plan be developed. The plan shall be developed and submitted to the Director and the parties within forty-five (45) days of the Director's determination of eligibility, unless said determination has been contested.

(B) In developing the plan, the rehabilitation vendor shall strive to return the qualified worker to suitable gainful employment within the qualified worker's medical and physical limitations as determined in the vocational evaluation in the following priorities:

(1) Return to work for the same employer to a modified job requiring rehabilitation services.

(2) Return to work for the same or a new employer in a related occupation, for which the individual has received rehabilitation services to upgrade skills attained from previous training or experience.

(3) Return to work in an on-the-job training capacity.

(4) Return to work after the completion of a vocational program into a new occupation.

(C) Once developed, the proposed plan shall be written and submitted to the parties on the form prescribed by the Director. The written plan shall include the minimum elements listed on the form. All parties shall sign the vocational plan prior to submitting the plan to the Director for approval. The Director may request additional information necessary to determine if the plan should be approved.

(D) The Director, upon receipt of a proposed vocational rehabilitation plan and upon review, shall order the plan either approved or disapproved or modified. Implementation of the plan may begin as soon as the qualified worker is capable of participating in the program, as indicated by competent medical evidence. The plan shall begin upon the Director's approval or the date specified in the plan as applicable, whichever is later. The insurer shall continue to provide temporary disability benefits, if applicable, until implementation of the plan and the employee begins his vocational rehabilitation program.

(E) All matters regarding rehabilitation plans or programs shall be initially submitted to the Director except in those cases where the question of need for vocational rehabilitation first arises during the course of a hearing or hearings on other issues.

(F) If there is a dispute regarding the vocational rehabilitation plan, the disputing party shall request a hearing by filing an application for hearing at the Office of Administrative Courts.

(G) If the qualified worker does not choose to enroll in a vocational rehabilitation program, nothing in these rules and regulations shall require the qualified worker to do so.

15-5 MODIFICATION, SUSPENSION OR TERMINATION OF THE VOCATIONAL REHABILITATION PLAN OR VOCATIONAL EVALUATION

(A) If a vocational evaluation or an approved vocational plan is modified, terminated or suspended for any reason, and the parties are in agreement, the Director shall be notified. Plan modifications shall be submitted to the Director for approval on the prescribed form for vocational plans.

(B) If there is a dispute regarding the progress of a vocational evaluation or vocational rehabilitation plan, the disputing party shall request a hearing by filing an application for hearing at the Office of Administrative Courts.

15-6 REPORTING REQUIREMENT

All vocational rehabilitation forms and reports 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.

15-7 QUALIFIED REHABILITATION VENDOR

(A) A vendor will be considered qualified by the Director if the vendor has the services of a consultant who had previously registered with the Division when the registration program existed or can demonstrate one of the following credentials:

(1) The individual is a Certified Rehabilitation Counselor under the guidelines of the Commission on Rehabilitation Counselor Certification or can demonstrate equivalent credentials.

(2) The individual has a Master's degree in Vocational Rehabilitation, Guidance and Counseling, Psychology, or in a related field or can demonstrate equivalent work experience on a year for year basis for formal education. The individual must also have one (1) year of experience as a practitioner in the field of vocational rehabilitation.

(3) The individual has a Bachelor's degree in Vocational Rehabilitation, Guidance and Counseling, Psychology, or a related field or can demonstrate equivalent work experience on a year for year basis for formal education. The individual must also have two (2) years experience as a practitioner in the field of vocational rehabilitation.

(B) If a dispute occurs concerning a counselor's credentials, the counselor shall submit to the Director a resume, transcripts, diploma and any other requested documentation. The Director will determine whether the counselor is qualified.

Rule 16 Utilization Standards

16-1 STATEMENT OF PURPOSE

In an effort to comply with the legislative charge to assure the quick and efficient delivery of medical benefits at a reasonable cost, the Director (Director) of the Division of Workers' Compensation (Division) has promulgated these utilization standards, effective January 1, 2023. This Rule defines the standard terminology, administrative procedures, and dispute resolution procedures required to implement the Division's Medical Treatment Guidelines (Rule 17) and Medical Fee Schedule (Rule 18).

16-2 STANDARD TERMINOLOGY FOR RULES 16, 17, AND 18

A. Ambulatory Surgical Center (ASC) means licensed as such by the Colorado Department of Public Health and Environment (CDPHE).

B. Authorized Treating Provider (ATP) means any of the following:

1. The treating physician designated by the employer and selected by the injured worker;

2. A healthcare provider to whom an ATP refers the injured worker for treatment, consultation, or impairment rating;

3. A physician selected by the injured worker when the injured worker has the right to select a provider;

4. A physician authorized by the employer when the employer has the right or obligation to make such an authorization;

5. A healthcare provider determined by the Director or an administrative law judge to be an ATP;

6. A provider who is designated by the agreement of the injured worker and the payer.

C. Billed Service(s) means any billed service, procedure, equipment, or supply provided to an injured worker by a Provider.

D. Billing Party means a service provider or an injured worker who has incurred authorized medical expenses.

E. Children's Hospital means federally qualified, and certified by CDPHE, and licensed as a general hospital by CDPHE.

F. Critical Access Hospital means federally qualified, and certified by CDPHE, and licensed as a general hospital by CDPHE. A list is available at www.ruralcenter.org/resource-library/cah-locations.

G. Day means a calendar day unless otherwise noted. In computing any period of time prescribed or allowed by Rules 16, 17, or 18, the parties shall refer to Rule 1-2.

H. Designated Provider List means a list of physicians as required under § 8-43-404(5)(a)(I) and Rule 8.

I. Freestanding Facility means an entity that furnishes healthcare services and is not integrated with any other entity as a main provider, a department of a provider, remote location of a hospital, satellite facility, or a provider-based entity.

J. Hospital means licensed as such by CDPHE.

K. Long-Term Acute Care Hospital means federally certified and licensed as such by CDPHE.

L. Medical Fee Schedule means Division's Rule 18, its exhibits and the documents incorporated by reference in that Rule.

M. Medical Treatment Guidelines (MTGs) means Division's Rule 17, its exhibits, and the documents incorporated by reference in that Rule.

N. Non-Physician Provider means individual who is registered, certified or licensed by the Colorado Department of Regulatory Agencies (DORA), the Colorado Secretary of State, or a national entity recognized by the State of Colorado as follows:

1. Acupuncturist (L.Ac) licensed by the Office of Acupuncture Licensure, DORA;

2. Advanced Practice Nurse (APN) licensed by the Colorado Board of Nursing, Advanced Practice Nurse Registry;

3. Anesthesiologist Assistant (AA) licensed by the Colorado Medical Board, DORA;

4. Athletic Trainer (ATC) licensed by the Office of Athletic Trainer Licensure, DORA;

5. Audiologist (AU.D. CCC-A) licensed by the Office of Audiology and Hearing Aid Provider Licensure, DORA;

6. Certified Medical Interpreter certified by the Certification Commission for Healthcare Interpreters or the National Board of Certification for Medical Interpreters.

7. Certified Registered Nurse Anesthetist (CRNA) licensed by the Colorado Board of Nursing;

8. Clinical Social Worker (LCSW) licensed by the Board of Social Work Examiners, DORA;

9. Durable Medical Equipment, Prosthetic, Orthotics, and Supplies (DMEPOS) Supplier licensed by the Colorado Secretary of State;

10. Marriage and Family Therapist (LMFT) licensed by the Board of Marriage and Family Therapist Examiners, DORA;

11. Massage Therapist licensed as a massage therapist by the Office of Massage Therapy Licensure, DORA;

12. Nurse Practitioner (NP) licensed as an APN and authorized by the Colorado Board of Nursing;

13. Occupational Therapist (OTR) licensed by the Office of Occupational Therapy, DORA;

14. Occupational Therapist Assistant (OTA) licensed by the Office of Occupational Therapy, DORA;

15. Pharmacist licensed by the Board of Pharmacy, DORA;

16. Physical Therapist (PT) licensed by the Physical Therapy Board, DORA;

17. Physical Therapist Assistant (PTA) licensed by the Physical Therapy Board, DORA;

18. Physician Assistant (PA) licensed by the Colorado Medical Board;

19 Practical Nurse (LPN) licensed by the Colorado Board of Nursing;

20. Professional Counselor (LPC) licensed by the Board of Professional Counselor Examiners, DORA, or an equivalent licensing board of a state that participates in the interstate compact pursuant to § 24-60-4301 et seq.;

21. Psychologist (PsyD, PhD, EdD) licensed by the Board of Psychologist Examiners, DORA;

22. Registered Nurse (RN) licensed by the Colorado Board of Nursing;

23. Respiratory Therapist (RTL) certified by the National Board of Respiratory Care and licensed by the Office of Respiratory Therapy Licensure, DORA;

24. Speech Language Pathologist (CCC-SLP) certified by the Office of Speech-Language Pathology Certification, DORA;

25. Surgical Assistant registered by the Office of Surgical Assistant and Surgical Technologists Registration, DORA.

O. Over-the-Counter Drugs means medications that are available for purchase by the general public without a prescription.

P. Payer means an insurer, self-insured employer, or designated agent(s) responsible for payment of medical expenses. (Use of agents, including but not limited to preferred provider organization (PPO) networks, bill review companies, third party administrators (TPAs), and case management companies shall not relieve the insurer or self-insured employer from their legal responsibilities for compliance with these Rules).

Q. Physician Provider means individual who is licensed by the State of Colorado through one of the following boards:

1. Colorado Medical Board;

2. Colorado Dental Board;

3. Colorado Podiatry Board;

4. Colorado Optometry Board; or

5. Colorado Board of Chiropractic Examiners.

R. Prior Authorization means a guarantee of payment for treatment requested in accordance with this Rule.

S. Provider means a person or entity providing authorized health care service, whether involving treatment or not, to a worker in connection with a work-related injury or occupational disease.

T. Psychiatric Hospital means licensed as such by CDPHE.

U. Rehabilitation Hospital means licensed as such by CDPHE.

V. Rural Health Clinic means a clinic located in areas designated by the United States Census Bureau as rural, or the state as medically underserved, that is federally qualified, and certified as such by CDPHE. A list is available at www.colorado.gov/pacific/cdphe/rural-health-clinic-consumer-resources.

W. Skilled Nursing Facility (SNF) means federally certified, and licensed as a nursing care facility by CDPHE.

X. State-run Psychiatric Hospital means mental health institute operated by the Colorado Department of Human Services, Office of Behavioral Health.

Y. Telemedicine means two-way, real time interactive communication between the injured worker and the provider at a distant site. This electronic communication involves, at a minimum, audio and video telecommunications equipment. Telemedicine enables the remote evaluation and diagnosis of injured workers in addition to the ability to detect fluctuations in their medical condition(s) at a remote site in such a way as to confirm or alter the treatment plan, including medications and/or specialized therapy.

Z. Treatment means any service, procedure, or supply prescribed by an ATP as may reasonably be needed at the time of the injury or occupational disease and thereafter to cure and/or relieve the employee from the effects of the injury or occupational disease.

AA. Veterans Administration Hospital means all medical facilities overseen by the United States Department of Veterans' Affairs.

AB. Writing, for the purposes of Rules 16 and 18, means transmitted by letter, email, fax, or other electronic means of communication.

16-3 GENERAL REQUIREMENTS

A. Any provider not listed in 16-2 must obtain Prior Authorization when providing services related to a compensable injury.

B. Upon request, healthcare providers must provide copies of accreditation, licensure, registration, certification, or evidence of healthcare training for billed services.

C. To the extent not otherwise precluded by the laws of this state, contracts between providers, payers, and any agents acting on behalf of providers or payers shall comply with this Rule.

D. Referrals:

1. All providers must have a referral from a physician provider managing the claim (or NP/PA working under that physician provider). A physician making the referral to another provider shall, upon request of any party, answer any questions and clarify the scope of the referral, prescription, or the reasonableness or necessity of the care.

2. A payer or employer shall not redirect or alter the scope of a referral to another provider for evaluation or treatment of a compensable injury. Any party who has concerns regarding a referral or its scope shall advise the other parties and providers involved.

E. Use of PAs and NPs:

1. All Colorado workers' compensation (WC) claims (medical only and lost time) shall have a Physician responsible for all services rendered to an injured worker by any PA or NP.

2. The Physician must evaluate the injured worker at least once within the first three visits to the Designated Provider's office.

3. For services performed by a PA or NP, the attending Physician must counter-sign patient records related to the injured worker's inability to work resulting from the claimed work injury or disease and the injured worker's ability to return to regular or modified employment, as required by §§ 8-42-105(2)(b) and (3)(c) and (d). The attending Physician must sign the WC 164 form, certifying that all requirements of this rule have been met.

16-4 OUT-OF-STATE PROVIDERS

A. Relocated Injured Worker

1. Upon receipt of the "Employer's First Report of Injury" or the "Worker's Claim for Compensation" form, the payer shall notify the injured worker that the procedures for change of provider can be obtained from the payer should the injured worker relocate out of state.

2. A change of provider must be made through referral by the Physician managing the claim or in accordance with § 8-43-404(5)(a).

B. In the event an injured worker has not relocated out of state but is referred to an out-of-state provider for treatment not available within Colorado, the referring provider shall obtain Prior Authorization. The referring provider's written request for out of state treatment shall include:

1. Description of treatment requested, including medical justification, the estimated frequency and duration, and known associated medical expenses;

2. Explanation as to why the requested treatment cannot be obtained within Colorado;

3. Name, complete mailing address, and phone number of the out-of-state provider; and

4. Out-of-state provider's qualifications to provide the requested treatment.

16-5 REQUIRED USE OF THE MEDICAL TREATMENT GUIDELINES

When an injury or occupational disease falls within the purview of Rule 17, Medical Treatment Guidelines and the injury occurs on or after July 1, 1991, providers and payers shall use the MTG, in effect at the time of service, to prepare or review their treatment plan(s) for the injured worker. A payer may not dictate the type or duration of medical treatment or rely on its own internal guidelines or other standards for medical determination. Initial recommendations for a treatment or modality should not exceed the time to produce functional effect parameters in the applicable MTG. When treatment exceeds or is outside of the MTGs, Prior Authorization is required. Requesters and reviewers should consider how their decision will affect the overall treatment plan for the individual patient. In all instances of denial, appropriate processes to deny are required.

16-6 NOTIFICATION TO TREAT

A. The Notification to Treat process applies to treatment that is consistent with the MTGs and has an established value under the Medical Fee Schedule. Providers may, but are not required to, utilize Notification to ensure payment for medical treatment that falls within the purview of the MTGs. The lack of response from the payer within the time requirement set forth below shall deem the proposed treatment authorized for payment.

B. Notification to Treat may be submitted by phone during regular business hours, or by submitting the "Authorized Treating Provider's Notification to Treat" form (WC 195). Notification to Treat must include:

1. Provider's certification that the proposed treatment is medically necessary and consistent with the MTGs.

2. Citation of the specific MTG applicable to the proposed treatment.

3. Provider's email address or fax number to which the payer can respond.

C. Payers shall respond to a Notification to Treat submission within seven days from the receipt of the submission with an approval or a denial of the proposed treatment. Providers may accept verbal confirmation or may request written confirmation, which the payer should provide upon request.

1. The payer may limit its approval of initial treatment to the number or duration specified in the relevant MTG without a medical review. If subsequent medical records document functional progress, additional treatment should be approved.

2. If payer proposes to discontinue treatment before the maximum number of treatments/treatment duration has been reached due to lack of functional progress, payer shall support that decision with a medical review compliant with this rule.

D. Payers may deny proposed treatment for the following reasons only:

1. For claims that have been reported to the Division, no admission of liability or final order finding the injury compensable has been issued;

2. Proposed treatment is not related to the admitted injury;

3. Provider submitting Notification is not an ATP or is proposing treatment to be performed by a provider who is not eligible to be an ATP.

4. Injured worker is not entitled to the proposed treatment pursuant to statute or settlement;

5. Medical records contain conflicting opinions among the ATPs regarding proposed treatment;

6. Proposed treatment falls outside of the MTGs.

E. If the payer denies a Notification to Treat per sections 16-6 D 2, 5, or 6, the payer shall notify the provider, allow the submission of relevant supporting medical documentation as defined in section 16-7 C and review the submission as a Prior Authorization request, allowing 10 additional days for review.

F. Appeals for denied Notifications to Treat shall be made in accordance with the Prior Authorization Appeals Process outlined in this rule.

G. Any provider or payer who incorrectly applies the MTGs in the Notification to Treat process may be subject to penalties under the Workers' Compensation Act.

16-7 PRIOR AUTHORIZATION

A. Prior Authorization may be requested using the "Authorized Treating Provider's Request for Prior Authorization" (Form WC 188) or in the alternative, shall be clearly labeled as a Prior Authorization request. Prior Authorization for payment shall only be requested when:

1. A prescribed treatment exceeds the recommended limitations set forth in the MTGs.

2. The MTGs require Prior Authorization for that specific service;

3. A prescribed treatment is not priced in the Medical Fee Schedule or is identified in Rule as requiring Prior Authorization for payment.

B. Prior Authorization for prescribed treatment may be granted immediately and without a medical review. However, the payer shall respond to all Prior Authorization requests in writing within 10 days from receipt of a completed request as defined per this Rule.

The payer, unless it has previously notified the provider, shall give notice to the provider of the procedures for obtaining Prior Authorization for payment upon receipt of the initial bill from that provider.

C. When submitting a Prior Authorization request, a provider shall concurrently explain the reasonableness and medical necessity of the treatment requested and shall provide relevant supporting documentation (documentation used in the provider's decision-making process to substantiate need for the requested treatment). A complete Prior Authorization request includes the following:

1. An adequate definition or description of the nature, extent and necessity for the treatment;

2. Identification of the appropriate MTG if applicable; and

3. Final diagnosis.

16-7-1 PRIOR AUTHORIZATION DENIALS

A. If an ATP requests Prior Authorization and indicates in writing, including reasoning and supporting documentation, that the requested treatment is related to the admitted WC claim, the payer cannot deny solely for relatedness without a medical opinion as required by this Rule. The medical review, independent medical examination (IME) report, or report from an ATP that addresses relatedness of the requested treatment to the admitted claim may precede the Prior Authorization request if:

1. The opinion was issued within 365 days prior to the date of the Prior Authorization request; and

2. An admission of liability has not been filed admitting the relatedness of the requested treatment to the admitted claim or a final order has not been entered finding the specific medical condition related to the admitted injury.

If not, the medical review, IME report, or report from the ATP must be subsequent to the prior authorization request.

B. The payer may deny a request for Prior Authorization for medical or non-medical reasons. Examples of non-medical reasons are listed in section 16-10-2 A.

1. If the payer is denying a request for non-medical reasons, the payer shall, within 10 days of receipt of the complete request, furnish the requesting ATP and the parties with a written denial that sets forth clear and persuasive reasons for the denial, including citation of appropriate statutes, rules, and/or supporting documents (e.g., a copy of claim denial or a detailed explanation why the requesting provider is not authorized to treat).

2. If the payer is denying a request for medical reasons, the payer shall, within 10 days of receipt of the complete request:

a. Have all of the submitted documentation reviewed by a Physician, who holds a license in the same or similar specialty as would typically manage the medical condition or treatment under review. The physician provider performing this review shall be Level I or II Accredited. In addition, clinical Pharmacists (Pharm.D.) may review Prior Authorization requests for medications, and Psychologists may review requests for mental health services, without having received Level I or II Accreditation.

After reviewing all of the submitted documentation and documentation referenced in the Prior Authorization request that is available to the payer, the reviewing Physician may call the requesting provider to expedite the communication and processing of the Prior Authorization request.

The payer may limit approval of initial treatment to the number or duration specified in the relevant MTG without a medical review.

b. Furnish the requesting ATP and the parties with a written denial that sets forth an explanation of the specific medical reasons for the denial, including the name and professional credentials of the provider performing the medical review and a copy of the reviewer's opinion; the specific citation from the MTGs, when applicable; and identification of the information deemed most likely to influence a reconsideration of the denial, when applicable.

16-7-2 PRIOR AUTHORIZATION APPEALS

A. The requesting ATP shall have 10 days from the date of the written denial to submit an appeal with additional information to support the request. A written response is not considered a "special report" as defined in Rule 18.

B. The payer shall have 10 days from the date of the appeal to issue a final decision and provide documentation of that decision to the provider and parties.

C. In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or the Office of Administrative Courts.

D. An urgent need for Prior Authorization of health care services, as recommended in writing by an ATP, shall be deemed good cause for an expedited hearing.

E. Failure of the payer to timely comply in full with all Prior Authorization requirements outlined in this rule shall be deemed authorization for payment of the requested treatment unless the payer has scheduled an independent medical examination (IME) and notified the requesting provider of the IME within the time prescribed for responding.

1. The IME must occur within 30 days, or upon first available appointment, of the Prior Authorization request, not to exceed 60 days absent an order extending the deadline.

2. The IME physician must serve all parties concurrently with the report within 20 days of the IME.

3. The payer shall respond to the Prior Authorization request within 10 days of the receipt of the IME report.

4. If the injured worker does not attend or reschedules the IME, the payer may deny the Prior Authorization request pending completion of the IME.

5. The IME shall comply with Rule 8 as applicable.

16-8 REQUIRED USE OF THE FEE SCHEDULE

A. All providers and payers shall use the Medical Fee Schedule to determine the maximum allowable payments for any medical treatments or services within the purview of the Workers' Compensation Act of Colorado and the Colorado Workers' Compensation Rules of Procedure, unless one of the following exceptions applies:

1. If billed charges are less than the fee schedule, the payment shall not exceed the billed charges.

2. The payer and an out-of-state provider may negotiate reimbursement in excess of the fee schedule when required to obtain reasonable and necessary care for an injured worker.

3. Pursuant to § 8-67-112(3), the Uninsured Employer Board may negotiate rates of reimbursement for medical providers.

B. The Medical Fee Schedule does not limit the billing charges.

C. Payment for treatment not identified or identified but without established value in the Medical Fee Schedule shall require Prior Authorization, except for when the treatment is an emergency. Similar established code values from the Medical Fee Schedule, determined in compliance with section 16-10-1 B, shall govern payment.

16-8-1 REQUIRED BILLING FORMS AND CODES

A. Medical providers shall use only the billing forms listed below or exact electronic reproductions. If the payer agrees, providers may place identifying information in the margin of the form. Payment for any service not billed on the forms identified below may be denied.

1. A CMS-1500 shall be used by all providers billing for professional services (unless otherwise specified below), DMEPOS, and ambulance services. Medical providers shall provide their name and credentials in box 31 of the CMS-1500. Non-hospital based ASCs may bill on the CMS-1500, however an SG modifier must be appended to the technical component of services to indicate a facility charge and to qualify for reimbursement as a facility claim.

   When resubmitting a claim, providers must append the appropriate resubmission code in field 22, or corresponding field for EDI, along with the original claim number in the right side of field 22 (original ref no.):

   1 – original claim (duplicate of a previously submitted that was never processed)

   7 – replacement/corrected claim (previously adjudicated with new or amended information)

   8 – void/cancel prior claim (previously paid claim that was submitted in error)

2. A UB-04 shall be used by all hospitals and facilities meeting definitions found in section 16-2, hospital-based ambulance/air services, and other providers, such as hospital-based ASCs, when billing for hospital/facility services.

   a. Some outpatient hospital therapy services may also be billed on a UB-04. For these services, the UB-04 must have Form Locator Type 13x, 074x, 075x or 085x, and one of the following revenue codes:

      042X - Physical Therapy
      043X - Occupational Therapy
      044X - Speech Therapy

   b. When resubmitting a claim, providers must append the appropriate resubmission code in box 4, or corresponding field for EDI, and the original claim number in field 64:

XX7 – correction/replacement or prior claim
XX8 – void/cancel of prior claim

3. American Dental Association's Dental Claim Form, Version 2019 shall be used by all providers billing for dental treatment.

4. An NCPDP (National Council for Prescription Drug Programs) Workers' Compensation/Property and Casualty universal claim form, version 1.1 shall be used by dispensing pharmacies and pharmacy benefit managers.

   An ANSI ASC X12 (American National Standards Institute Accredited Standards Committee) or NCPDP electronic billing transaction containing the same information as in 1, 2, or 3 of this subsection may be used with payer agreement.

5. An invoice or other agreed upon form may be used for services incident to medical treatment, such as guardian ad litem and conservator services, language interpreting, or mileage reimbursement.

B. International Classification of Diseases (ICD) Codes

All medical provider bills shall list the ICD-10 Clinical Modification (CM) diagnosis code(s) that are current, accurate, and specific to each patient encounter, in accordance with the ICD-10-CM Chapter Guidelines provided by CMS (Centers for Medicare & Medicaid Services). Bills should include the External Causes code(s). ICD-10 codes shall not be used as a sole factor to establish work-relatedness of an injury or treatment.

C. Medical providers must accurately report their services using applicable billing codes, modifiers, instructions, and parenthetical notes as incorporated by reference in Rule 18. The provider may be subject to penalties for inaccurate billing when the provider knew or should have known that the treatment billed was inaccurate, as determined by the Director or an administrative law judge.

D. National provider identification (NPI) numbers are required for WC bills. Provider types ineligible to obtain NPI numbers are exempt from this requirement. When billing on a CMS-1500, Dental Claim Form, or UB-04, the NPI shall be that of the rendering provider and shall include the correct place of service code(s) at the line level.

16-8-2 TIMELY FILING

A. Providers shall submit their bills for treatment rendered within 120 days of the date of service or the bill may be denied unless extenuating circumstances exist.

1. For bills submitted through electronic data interchange (EDI), providers may prove timely filing by showing a payer acknowledgement (claim accepted). Rejected claims or clearinghouse acknowledgement reports are not proof of timely filing.

2. For paper bills, providers may prove timely filing with a signed certificate of mailing listing the original date mailed and the payer's address; a fax acknowledgement report; or a certified mail receipt showing the date the payer received the bill.

3. All timely filing issues will be considered final 10 months from the date of service unless extenuating circumstances exist.

B. Injured workers shall submit requests for mileage reimbursement within 120 days of the date of service or reimbursement may be denied unless good cause exists.

C. Extenuating circumstances/good cause may include, but are not limited to, delays in compensability being determined or the party has not been informed of this benefit or where to send the bill.

16-9 REQUIRED MEDICAL RECORD DOCUMENTATION

A. The treating provider shall maintain medical records for each injured worker when billing for the provided treatment. The rendering provider shall sign the medical records. Electronic signatures are accepted.

B. All medical records shall legibly document the treatment billed and shall include at least the following information:

1. Patient's name;

2. Date of treatment;

3. Name and professional designation of person providing treatment;

4. Assessment or diagnosis of current condition with appropriate objective findings;

5. Treatment provided;

6. Treatment plan, when applicable; and

7. If being completed by an authorized treating physician, all pertinent changes to work and or activity restrictions which reflect lifting, standing, stooping, kneeling, hot or cold environment, repetitive motion or other appropriate physical considerations.

C. All treatment provided to injured workers is expected to be documented in the medical record at the time it is rendered. Occasionally, certain entries related to treatment provided are not made timely. In this event, the documentation will need to be amended, corrected, or entered after rendering treatment. Amendments, corrections, and delayed entries must comply with Medicare's widely accepted recordkeeping principles as outlined in the Medicare Program Integrity Manual Chapter 3, section 3.3.2.5, implemented August 2020. (This section does not apply to injured workers' requests to amend records as permitted by the Health Insurance Portability and Accountability Act (HIPAA)).

D. The ATP must sign (or counter-sign) and submit to the payer, within 14 days of the initial and final visit, a completed WC 164 form.

1. The form shall be completed as an "initial" report when the injured worker has the initial visit with the Designated Physician, or in the case of a transfer of care, the new Designated Physician. If applicable, the emergency department (ED) or urgent care physician initially treating the injury may also complete a WC 164 initial report. In such cases, the initial report from the ED or urgent care physician, and the Designated Physician shall be reimbursed. Unless requested or prior authorized by the payer, no other physician should complete and bill for the WC 164 initial report. See Rule 18 for required fields.

2. The form shall be completed as a "closing" report when the ATP managing the total WC claim determines the injured worker has reached maximum medical improvement (MMI) for all covered injuries or diseases, with or without permanent impairment. See Rule 18 for required fields.

3. The ATP shall supply the injured worker with a copy of the WC 164 at the time of completion, at no charge.

E. Providers other than hospitals shall provide the payer with all supporting documentation and treatment records at the time of billing unless the parties have made other agreements. Hospitals shall provide documentation to the payer upon request. Payers shall specify what portion of a hospital record is being requested (for example, only the ED chart notes, in-patient physician orders and chart notes, x-rays, pathology reports, etc.). The payer may deny payment for billed treatment until the provider submits the required medical documentation.

16-10 PAYMENT REQUIREMENTS FOR MEDICAL BILLS

A. All bills submitted by a provider are due and payable in accordance with the Medical Fee Schedule within 30 days after receipt by the payer, unless the payer provides timely and proper reasons set forth by section 16-10-2 or 3.

B. For every medical treatment bill submitted by a provider, the payer shall reply with a written notice (explanation of benefits) within 30 days of receipt of the bill that includes the following:

1. Injured worker's name;

2. Payer's name and address;

3. Date(s) of service;

4. Each procedure code billed; and

5. Amount paid.

C. If any adjustment is made to the amount submitted on the bill, the payer's written notice shall also include:

1. Payer's claim number and/or Division's WC number;

2. Specific identifying information coordinating the notice with any payment instrument associated with the bill;

3. Notice that the billing party may submit a corrected bill or an appeal within 60 days;

4. Name of insurer with admitted, ordered, or contested liability for the WC claim, when known;

5. Name and address of any third-party administrator (TPA) and/or bill reviewer associated with processing the bill;

6. Name and contact information of a person who has responsibility and authority to discuss and resolve disputes on the bill;

7. Name and address of the employer, when known;

8. For compensable treatment related to a work injury, the payer shall notify the billing party that the injured worker shall not be balance-billed;

9. If applicable, a statement that the payment is being held in abeyance because a hearing is pending on a relevant issue.

D. Any written notice that fails to include the required information is defective and does not satisfy the 30-day notice requirement.

E. If the payer discounts a bill and the provider requests clarification in writing, the payer shall furnish to the requester the specifics of the discount within 30 days, including a copy of any contract relied upon for the discount. If no response is forthcoming within 30 days, the payer must pay the maximum Medical Fee Schedule allowance or the billed charges, whichever is less.

F. Date of bill receipt by the payer may be established by the payer's date stamp or electronic acknowledgment date required by Rule 4; otherwise, receipt is presumed to occur five days after the date the bill was mailed to the payer's correct address.

G. Payers shall reimburse injured workers for mileage expenses as required by statute or provide written notice of the reason(s) for denying reimbursement within 30 days of receipt.

H. An injured worker shall never be required to directly pay for admitted or ordered medical benefits covered under the Workers' Compensation Act. In the event the injured worker has directly paid for medical treatment that is then admitted or ordered under the Workers' Compensation Act, the payer shall reimburse the injured worker for the amounts actually paid for authorized treatment within 30 days of receipt of the bill. If the actual costs exceed the maximum fee allowed by the Medical Fee Schedule, the payer may seek a refund from the medical provider for the difference between the amount charged to the injured worker and the maximum fee.

16-10-1 MODIFIED, UNLISTED, AND UNPRICED CODES

A. Prior to modifying a billed code, the payer must contact the billing provider and determine if the code is accurate. If the payer disagrees with the level of care billed, the payer may deny the claim or contact the provider to explain why the billed code does not meet the level of care criteria.

1. If the billing provider agrees with the payer, then the payer shall process the service with the agreed upon code and shall document on the written notice the agreement with the provider. The written notice shall include the name of the party at the billing office who made the agreement.

2. If the billing provider disagrees with the payer, then the payer shall proceed with a denial.

B. When no established fee is identified in the Medical Fee Schedule and the payer agrees the service or procedure is reasonable and necessary, the payer shall list on the written notice one of the following payment options:

1. Payment based on a similar established code value as recommended by the billing provider.

2. A reasonable value based upon a similar established code value as determined by the payer.

If the payer disagrees with the billing provider's recommended code value, the denial shall include an explanation of why the requested fee is not reasonable, identification of the similar code as determined by the payer, and how the payer calculated its fee recommendation. If the provider disagrees with the payer's determination, it can follow the process for appealing billed treatment denials.

16-10-2 DENYING PAYMENT OF BILLED TREATMENT FOR NON-MEDICAL REASONS

A. Non-medical reasons are administrative issues that do not require medical documentation review other than to verify the appropriate use of a billed code. Examples of non-medical reasons for denying payment include the following: no WC claim has been filed with the payer; compensability has not been established; the provider is not authorized to treat; the insurance coverage is at issue; typographic or date errors on the bill; failure to submit medical documentation; or unrecognized or improper use of a CPT® code.

B. If an ATP bills for medical treatment and indicates in writing, including reasoning and relevant documentation that the medical services are related to the admitted WC claim, the payer cannot deny payment solely for relatedness without a medical opinion as required by section 16-10-3. The medical review, IME report, or report from an ATP that addresses the relatedness of the requested treatment to the admitted claim may precede the date of service, unless the requesting physician presents new evidence as to why treatment is now related.

C. In all cases where a billed treatment is denied for non-medical reasons, the payer's written notice shall include all notice requirements set forth in sections 16-10 B and C, and shall also include:

1. Reference to each code being denied; and

2. Clear and persuasive reasons for denying payment, including citation of appropriate statutes, rules, and/or documents supporting the payer's reason(s).

D. If after the treatment was provided, the payer agrees the service was reasonable and necessary, lack of prior authorization does not warrant denial of payment. However, the provider may still be required to provide additional supporting documentation as outlined in section 16-7 for a complete Prior Authorization request.

16-10-3 DENYING PAYMENT OF BILLED TREATMENT FOR MEDICAL REASONS

A. The payer shall have the bill and all supporting medical documentation reviewed by a Physician who holds a license and is in the same or similar specialty as would typically manage the medical condition or treatment under review. The Physician shall be Level I or II Accredited. In addition, a clinical Pharmacist (Pharm.D.) may review billed services for medications, and a Psychologist may review billed services for mental health, without having received Level I or II Accreditation. After reviewing the supporting medical documentation, the reviewing provider may call the billing provider to expedite communication and timely processing of the bill.

B. In all cases where a billed treatment is denied for medical reasons, the payer's written notice shall include all notice requirements set forth in sections 16-10 B and C, and shall also include:

1. Reference to each code being denied;

2. Clear and persuasive medical reasons for denying payment, including the name and professional credentials of the provider performing the medical review and a copy of the reviewer's opinion;

3. Citation from the MTGs, when applicable; and

4. Identification of additional information deemed likely to influence reconsideration, when applicable.

16-10-4 APPEALING BILLED TREATMENT DENIALS

A. The billing party shall have 60 days from the date of the written notice to request reconsideration. The billing party's appeal must include:

1. A copy of the original or corrected bill with condition code W3 in field 10d;

2. A copy of the written notice;

3. Identification of the specific code being appealed; and

4. Clear and persuasive reason(s) for the appeal, including additional supporting documentation when applicable.

B. If the billing party appeals the denial in compliance with above requirements, the payer shall:

1. When denied for non-medical reasons, have the bill and all supporting documentation reviewed by a person who has knowledge of the bill. After reviewing the provider's appeal, the reviewer may call the appealing party to expedite the communication and timely processing of the appeal.

2. When denied for medical reasons, have the bill and all supporting documentation reviewed by a Physician who holds a license and is in the same or similar specialty as would typically manage the medical condition or treatment under review. The Physician shall be Level I or II Accredited. In addition, a clinical pharmacist (Pharm.D.) may review appeals for payment of medications and a Psychologist may review appeals for payment of mental health services without having received Level I or II Accreditation. After reviewing the supporting medical documentation, the reviewing provider may call the appealing provider to expedite communication and timely processing of the appeal.

3. If after reviewing the appeal the payer agrees with the billing party, payment for treatment is due and payable in accordance with the Medical Fee Schedule within 30 days of receipt of the appeal. Date of receipt may be established by the payer's date stamp or electronic acknowledgment date required by Rule 4; otherwise, receipt is presumed to occur five days after the date the response was mailed to the payer's correct address.

4. If after reviewing the appeal the payer upholds its denial, the payer shall send the billing party written notice within 30 days of receipt of the appeal. The written notice shall include all notice requirements set forth in sections 16-10 B and C, and shall also include:

a. Reference to each code being denied;

b. Clear and persuasive medical or non-medical reasons for upholding the denial, including the name and professional credentials of the reviewer and a copy of the reviewer's opinion when medically based;

c. Citation of appropriate statutes, rules, and/or documents supporting the payer's reason(s).

5. In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or the Office of Administrative Courts. The parties shall do so within 12 months of the date of the original bill should have been processed in compliance with section 16-10, unless extenuating circumstances exist.

16-11 RETROACTIVE REVIEW OF MEDICAL BILLS

A. All medical bills shall be considered final at 12 months after the date of the original written notice unless the provider is notified that:

1. A hearing is requested within the 12 month period; or

2. A request for utilization review has been filed pursuant to § 8-43-501.

B. If the payer conducts a retroactive review to recover overpayments from a provider based on non-medical reasons, the payer shall send the billing party written notice that includes all notice requirements set forth in sections 16-10 B and C, and shall also include:

1. Reference to each item of the bill for which the payer seeks to recover payment:

2. Clear and persuasive reason(s) for seeking recovery of overpayment(s), including citation of appropriate statutes, rules and/or documents supporting the payer's reason(s).

3. Evidence that these payments were in fact made to the provider.

C. If the payer conducts a retroactive review to recover overpayments from a provider, based on medical reasons, the payer shall have the bill and all supporting documentation reviewed by a Physician, who holds a license and is in the same or similar specialty as would typically manage the medical condition or treatment under review. The Physician shall be Level I or II Accredited. In addition, a clinical pharmacist (Pharm.D.) may review billed medications, and a Psychologist may review billed services for mental health, without having received Level I or II Accreditation. The payer shall send the billing party written notice that includes all notice requirements set forth in sections 16-10 B and C, and 16-11 B.

D. In the event of disagreement, the parties may follow dispute resolution and adjudication procedures available through the Division or the Office of Administrative Courts.

16-11-1 ONSITE REVIEW OF HOSPITAL OR MEDICAL FACILITY CHARGES

A. If the payer conducts a review of billed and non-billed hospital or medical facility charges related to a specific workers' compensation claim, the payer shall comply with the following procedures:

1. Within 30 days of receipt of the bill, send written notification to the hospital or medical facility of its intent to conduct a review. Notification shall include the following information:

    a. Name of the injured worker;

    b. Division's WC number and/or hospital or medical facility patient identification number;

    c. An outline of the items to be reviewed; and

    d. Name and contact information of a person designated by the payer to conduct the review, if applicable.

B. The reviewer shall comply with the following procedures:

1. Obtain a signed release of information form from the injured worker;

2. Negotiate with the hospital or medical facility on a starting date for the review;

3. Assign staff members who are familiar with medical terminology, general hospital or medical facility charging, and medical documentation procedures or have a level of knowledge equivalent at least to that of an LPN;

4. Establish a schedule for the review which shall include, at a minimum, the dates for the delivery of preliminary findings to the hospital or medical facility, a 14 day response period for the hospital or medical facility, the delivery of an itemized list of any discrepancies, and an exit conference upon completion of the review; and

5. Provide the payer and hospital or medical facility with a written summary of the review within 30 days of the exit conference.

C. The hospital or medical facility shall comply with the following procedures:

1. Allow the review to begin within 30 days from the payer's notification;

2. Upon receipt of the injured worker's signed release of information form, allow the reviewer access to all items identified on the form;

3. Designate an individual to serve as the primary liaison between the hospital or medical facility and the reviewer, who will acquaint the reviewer with the documentation and charging practices of the hospital or medical facility;

4. Provide a written response to each preliminary review finding within 14 days of receipt of those findings; and

5. Participate in the exit conference in an effort to resolve any discrepancies.

16-12 DISPUTE RESOLUTION PROCESS

When seeking dispute resolution from the Division's Medical Dispute Resolution Unit, the requesting party must complete the Division's "Medical Dispute Resolution Intake Form" (WC 181) found on the Division's web page. The items listed on the bottom of the form must be provided at the time of submission. If necessary items are missing or if more information is required, the Division will forward a request for additional information and initiation of the process may be delayed.

When the request is properly made and the supporting documentation submitted, the Division will issue a confirmation of receipt. If, after reviewing the materials, the Division believes the dispute criteria have not been met, the Division will issue an explanation of those reasons. If the Division determines there is cause for facilitating the disputed items, the other party will be sent a request for a written response due in 14 days.

The Division will facilitate the dispute by reviewing the parties' compliance with Rules 11, 16, 17, and 18 within 30 days of receipt of the complete supporting documentation; or as soon thereafter as possible. In addition, the payer shall pay interest at the rate of eight percent per annum in accordance with § 8-43-410(2), upon all sums not paid timely and in accordance with the Division Rules. The interest shall be paid at the same time as any delinquent amount(s).

Upon review of all submitted documentation, disputes resulting from violation of Rules 11, 16, 17, and 18, as determined by the Director, may result in a Director's Order that cites the specific violation.

Evidence of compliance with the order shall be provided to the Director. If the party does not agree with the findings, it shall state with particularity and in writing its reasons for all disagreements by providing a response with all relevant legal authority, and/or other relevant proof in support of its position(s).

Failure to respond or cure violations may result in penalties in accordance with § 8-43-304. Daily fines up to $1,000/day for each such offence will be assessed until the party complies with the Director's Order.

Resolution of disputes not pertaining to Rule violations will be facilitated by the Division to the extent possible. In the event both parties cannot reach an agreement, the parties will be provided additional information on pursuing resolution and adjudication procedures available through the Office of Administrative Courts. Use of the dispute resolution process does not extend the 12-month application period for hearing.

Rule 17 Medical Treatment Guidelines

17-1. STATEMENT OF PURPOSE

The Director adopts the Medical Treatment Guidelines pursuant to § 8-42-101(3.5)(a)(II). The purpose of these Guidelines is to comply with § 8-40-102(1) and assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation.

17-2. USE OF THE MEDICAL TREATMENT GUIDELINES

(A) All health care providers shall use the Medical Treatment Guidelines promulgated by the Director, as required by § 8-42-101(3)(B).

(B) Payers shall routinely and regularly review claims to ensure that care is consistent with the Division's Medical Treatment Guidelines.

17-3. PROVIDER'S RESPONSIBILITIES

(A) The health care provider shall prepare a diagnosis-based treatment plan that includes specific treatment goals with expected time frames for completion in all cases where treatment falling within the purview of the Medical Treatment Guidelines continues beyond 6 weeks.

(B) Within 14 days of request by any party, the provider shall supply a copy of the treatment plan both to the patient and to the payer. Should the patient otherwise require care that deviates from the Medical Treatment Guidelines, the provider shall supply the patient and the payer with a written explanation of the medical necessity for such care.

17-4. PROCEDURE FOR QUESTIONING CARE

(A) The Medical Treatment Guidelines set forth reasonable medical care for high cost or high frequency categories of occupational injury or disease. However, the Division recognizes reasonable medical care may include deviations from the Guidelines in individual cases.

The provider shall request Prior Authorization if the proposed treatment falls outside the Medical Treatment Guidelines or if the Guidelines or Division Rules require Prior Authorization for a proposed treatment. The provider *may* submit a Notification to Treat to receive a guarantee of payment.

(B) Rule 16 governs the contest of a request for Prior Authorization or a claim for payment.

17-5. EXHIBITS TO RULE 17

(A) Exhibit 1 – Low Back Pain

(B) Exhibit 2A – Mild Traumatic Brain Injury

(C) Exhibit 2B – Moderate/Severe Traumatic Brain Injury

(D) Exhibit 3 – Thoracic Outlet Syndrome

(E) Exhibit 4 – Shoulder Injury

(F) Exhibit 5 – Cumulative Trauma Conditions

(G) Exhibit 6 – Lower Extremity

(H) Exhibit 7 – Complex Regional Pain Syndrome / Reflex Sympathetic Dystrophy

(I) Exhibit 8 – Cervical Spine Injury

(J) Exhibit 9 – Chronic Pain Disorder

Editor's Notes

7 CCR 1101-3 has been divided into smaller sections for ease of use. Versions prior to 01/01/2011 and rule history are located in the first section, 7 CCR 1101-3. Prior versions can be accessed from the All Versions list on the rule's current version page. To view versions effective on or after 01/01/2011, select the desired part of the rule, for example 7 CCR 1101-3 Rules 1-17, or 7 CCR 1101-3 Rule 17, Exhibit 1.

History

[For history of this section, see Editor's Notes in the first section, 7 CCR 1101-3]