DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation

WORKERS' COMPENSATION RULES OF PROCEDURE WITH TREATMENT GUIDELINES

7 CCR 1101-3 Rules 1- 17 (no exhibits)

[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 mee ts the definition of "employee" in the Act.

(G) "Employer" means anyone who mee ts 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.

1-2 COMPUTATION OF TIME/DATE OF FILING

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. Computation of days is consistent with Rule 6 of the Colorado Rules of Civil Procedure.

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.

(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 PENALTIES

Whenever any rule in the Workers' Compensation Rules of Procedure has been violated, the Director may impose penalties authorized by the Act.

1-8 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 Premium Surcharges

2-1 PREMIUM REPORTING REQUIREMENTS

Every insurance carrier shall semi-annually file a surcharge return with the Division within the time period specified in section 2-4 of this rule. The return shall be verified by affidavits of its president and secretary or other chief officers or agents, and shall state the amount of premiums written, including any policy expense constants, membership fees, finance and service, or other administrative fees charged to the policyholder in connection with the issuance or renewal of a policy, as reported to the Division of Insurance in accordance with §10-3-208, C.R.S., and regulations promulgated thereunder, during the period covered by such return. With this filing the insurance carrier shall pay the surcharges required by statute. Forms for such returns shall be provided by the Division.

2-2 PAYROLL REPORTING REQUIREMENTS

Every self-insured employer shall semi-annually file a surcharge return with the Division, within the time period specified in section 2-4 of this rule. The return shall be verified by affidavits of its president and secretary or other chief officers or agents, and shall state the total amount of its payroll for the period covered by such return. With this filing the employer shall pay the surcharges required by statute. Forms for such return shall be provided by the Division.

2-3 COMPUTATION OF PAYROLL SURCHARGES PAID BY SELF-INSURED EMPLOYERS

(A) Surcharges paid by self-insured employers shall be based upon the manual premium, adjusted by Pinnacol Assurance discounts applicable for the surcharge period covered and modified by the experience rating factor as calculated by the National Council on Compensation Insurance (NCCI). No other rating factor shall be allowable. The self-insured employer may elect not to provide such a rating factor; however, failure to submit the required rating factor will result in the premium surcharge being computed on the basis of manual premium only.

(B) If the self-insured employer is unable to develop the experience rating factor due to the unavailability of reliable and adequate data, the employer may apply to the Director for approval to use a 1.0 experience rating factor for the following two semiannual surcharge periods. If at the conclusion of the two semiannual surcharge periods that the 1.0 factor is used, the NCCI has been unable to develop an experience modification, the Director may permit an extension of time for the 1.0 factor to be used.

(C) In order that consideration be given to the experience modification, a completed NCCI form setting

forth all of the information and methodology used in the calculation of the experience modification shall accompany each corresponding payroll report.

2-4 PAYMENT PERIODS AND CREDITS

(A) The premium and payroll surcharges for the semiannual period beginning July 1, shall be based upon premiums written, including any policy expense constants, membership fees, finance and service, or other administrative fees charged to the policyholder in connection with the issuance or renewal of a policy, as reported to the Division of Insurance in accordance with §10-3-208, C.R.S., and regulations promulgated thereunder, for Colorado workers' compensation insurance or the self-insured employer's total payroll during the previous six months, and shall be paid to the Division on or before July 31 of that year, with a return form provided by the Division.

(B) The premium and payroll surcharges for the semiannual period beginning January 1 shall be based upon premiums written, including any policy expense constants, membership fees, finance and service, or other administrative fees charged to the policyholder in connection with the issuance or renewal of a policy, as reported to the Division of Insurance in accordance with §10-3-208, C.R.S., and regulations promulgated thereunder, for Colorado workers' compensation insurance or the self-insured employer's total payroll during the previous six months, and shall be paid to the Division on or before January 31 of that year, with a return form provided by the Division.

(C) An insurance carrier is entitled to a credit for canceled or returned premiums, including any policy expense constants, membership fees, finance and service, or other administrative fees charged to the policyholder in connection with the issuance or renewal of a policy, as reported to the Division of Insurance in accordance with §10-3-208, C.R.S., and regulations promulgated thereunder, actually refunded. The credit must be taken as an offset against surcharges due within one year of the date the premium amount was refunded.

(D) An insurance carrier or employer is not entitled to offset a credit of one subsidiary against the surcharge owed by another subsidiary.

2-5 SURCHARGE RATE

(A) For the annual period beginning July 1, 2010 and continuing indefinitely with annual review by the Director, the workers' compensation cash fund premium surcharge rate authorized under §8-44-112(1)(a), C.R.S., shall be 1.6 percent of the amount of all premiums written, including any policy expense constants, membership fees, finance and service, or other administrative fees charged to the policyholder in connection with the issuance or renewal of a policy, as reported to the Division of Insurance in accordance with §10-3-208, C.R.S., and regulations promulgated thereunder, or the premium equivalent amount established in section 2-3 of this rule, for Colorado workers' compensation insurance during the period of January 1, 2010 continuing indefinitely.

(B) For the purpose of funding the direct and indirect costs of the Premium Cost Containment program of the Division as authorized under §8-44-112(1)(b)(I), C.R.S., there is added to the surcharge imposed pursuant to Section 2-5 of this rule, an additional increment for the annual period beginning July 1, 2010 and continuing indefinitely with annual review by the Director, against workers’ compensation insurance premiums written, including any policy expense constants, membership fees, finance and service, or other administrative fees charged to the policyholder in connection with the issuance or renewal of a policy, as reported to the Division of Insurance in accordance with §10-3-208, C.R.S., and regulations promulgated thereunder, during the period of January 1, 2010, continuing indefinitely. The amount of this assessment shall be 0.03 percent. No assessment shall be imposed upon self-insured employers under this subsection.

(C) For the purposes of funding the financial liabilities of the Subsequent Injury Fund as authorized under §8-46-102(2)(A)(I), C.R.S. And the Major Medical Fund under §8-46-202, C.R.S., for

the period beginning July 1, 2010, and continuing indefinitely with annual review by the Director, the tax shall be assessed at 0.1 percent of the amount of Workers' Compensation premiums written, including any policy expense constants, membership fees, finance and service, or other administrative fees charged to the policyholder in connection with the issuance or renewal of a policy, as reported to the Division of Insurance in accordance with §10-3-208, C.R.S., and regulations promulgated thereunder, or the premium equivalent amount established in Section 2-3 of this rule, for Colorado Workers' Compensation insurance during the period of January 1, 2010, continuing indefinitely.

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.

(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, C.R.S.

(D) Every employer shall provide on request to its insurance carrier all federal employer identification number(s) ("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 I.D. numbers shall be reported immediately to the insurance carrier. The insurance carrier shall report all changes in FEINS and taxpayer I.D. numbers to NCCI within thirty (30) calendar days of receipt.

(E) 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 as referenced in §8-43-409(1), may be conducted, as determined by the Director, by any competent person appointed by the Director under § 8-43-208 or § 8-47-101 or by such other person as the Director may designate.

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 ELECTION TO REJECT COVERAGE

(A) An officer of a corporation or a member of a Limited Liability Company who elects to reject the provisions of the Act under §8-41-202, C.R.S., shall complete the Division prescribed form and send it or a substantial equivalent, to the insurance carrier for the corporation's or company's other employees, if any, by certified mail. An agricultural corporation electing to reject coverage for its corporate officers pursuant to §8-40-302(6), C.R.S., shall notify the insurance carrier in writing. If there is no insurance carrier, such documents shall be provided, by certified mail, to the Division.

(B) 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.

3-5 NOTICES TO EMPLOYEES

(A) Every employer shall continuously post a notice to employees in one or more conspicuous places on the employer's work site 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, and containing information about the Colorado workers' compensation system on a form prescribed or approved by the Division and furnished by the carrier or self-insured.

(B) Every employer also shall continuously post a notice to employees in one or more conspicuous places on the employer's work site advising employees that written notice must be given to an employer within 4 working days after an injury as set forth in §8-43-102(1) or (1.5), C.R.S.

3-6 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 the Director's initial finding that an employer is or was in default of its insurance obligations, daily fines up to $250/day for each day of default will be assessed in accordance with the following schedule of fines until the employer complies with the requirements of the Workers' Compensation Act regarding insurance or until further order of the Director:

Class I	1-20 Days	$ 5/Day
Class II	21-25 Days	$10/Day
Class III	26-30 Days	$30/Day
Class IV	31-35 Days	$50/Day
Class V	36-40 Days	$100/Day
Class VI	41 Days >	$250/Day

(C) Where the Director determines that an employer was required to but did not have a policy of workers' compensation insurance in place during any period between July 1, 2005 and 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 may regard such violation as a Class I violation under Rule 3-6 (B) and impose the fine therein provided for each day of the employer's default during such period.

(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 assessed in accordance with the following schedule of fines until the employer complies with the requirements of the Workers' Compensation Act regarding insurance or until further order of the Director:

Class VII	1- 20 Days	$250/Day
Class VIII	21-25 Days	$260/Day
Class IX	26-30 Days	$280/Day
Class X	31-35 Days	$300/Day
Class XI	36-40 Days	$400/Day
Class XII	41 Days >	$500/Day

Rule 4 Carrier Compliance

4-1 COMPLIANCE AUDITS

(A) Every insurer shall submit to compliance audits of its claims by the Division of Workers' Compensation. 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. Compliance audits are a method for the Division to regulate and oversee the Workers' Compensation System. A compliance audit conducted pursuant to this Rule 4 is intended to be an autonomous process.

(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. If additional information is requested for the compliance audit, it must be provided. 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 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 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) For the categories listed in subparagraphs 1 through 7 in paragraph (B) of this Rule 4-1, fines will be imposed for the repeated failure to demonstrate satisfactory compliance. A compliance level of 90% or higher 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 the disagreements and provide therewith 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 granted to the insurer to submit its written reasons for disagreement and to provide the authority and/or proof upon which it relies as is required by this rule by filing a written request for such extension of time with the auditor prior to the expiration of the 30 calendar days afforded to the insurer to agree with the preliminary findings. Any disagreement not so submitted to the auditor within the 30 day period or within such additional time as was granted in response to the insurer's written request for an extension of time is waived.

(2) The auditor, the auditor's manager 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 auditor, the auditor's manager, 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 the Director's 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, the Director will thereafter cause the Final Audit Report to be prepared and/or order such other action as the Director may determine warranted.

(5) When the insurer has agreed to the preliminary audit findings without disagreement, or when the insurer fails to disagree therewith in the manner provided in this Rule 4-1(D) or, when the insurer agrees to the preliminary findings before the time for referral to the Director under Rule 4-1(D)(4) has occurred, 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

(A) An insurer's first 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 finable compliance category is as follows:

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

FINES PER AUDIT DEFICIENCY PER COMPLIANCE CATEGORY

Compliance Level	1st Finable Occurrence	2nd Finable Occurrence	3rd and Later Finable Occurrence

80-89%	$30	$60	$90
70-79%	60	90	120
60-69%	90	120	150
< 60%	120	150	180

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

FINES PER AUDIT DEFICIENCY PER COMPLIANCE CATEGORY

Compliance level	1st Finable Occurrence	2nd Finable Occurrence	3rd and Later Finable Occurrence
80-89%	$50	$100	$200
70-79%	100	200	400
60-69%	200	400	600
< 60%	400	600	1000

Rule 5 Claims Adjusting Requirements

5-1 COMPLETION OF DIVISION FORMS

(A) Information required on Division forms shall be typed or legibly written in black or blue ink, completed in full and in accordance with Division requirements as to form and content. Forms that do not comply with this rule may not be accepted for filing. Position statements relative to liability which do not meet Division requirements will be returned to the insurer.

(B) Insurers may transmit data in an electronic format as directed by the Division.

(C) Effective July 1, 2006, all first reports of injury and notices of contest that are required to be filed with the Division shall be transmitted electronically. Transmitted electronically includes either electronic data interchange (EDI), or via the Division's internet filing process. First Reports of Injury and Notices of Contest cannot be submitted via electronic mail.

(D) The Director may grant an exemption to an insurer from filing electronically because of a small number of filings or financial hardship. Any insurer requesting an exemption from electronic filing may do so in letter form addressed to the Director. The request should provide specific justification(s) for the requested exemption. The letter should address whether an exemption is sought for only EDI or also for internet filing.

5-2 FILING OF EMPLOYERS' FIRST REPORTS OF INJURY

(A) Within ten days of notice or knowledge an employer shall report any work-related injury, illness or exposure to an injurious substance as described in subsection (F), to the employer's insurer. An employer who does not provide the required notice may be subject to penalties or other sanctions.

(B) A First Report of Injury shall be filed with the Division in a timely manner whenever any of the following apply. The insurer or third-party administrator may file the First Report of Injury on behalf of the employer.

(1) In the event of an injury that results in a fatality, or an accident in which three or more employees are injured, the Division shall be notified immediately.

(2) Within ten days after notice or knowledge by an employer that an employee has contracted an occupational disease listed below, or the occurrence of a permanently physically impairing injury, or that an injury or occupational disease has resulted in lost time from work for the injured employee in excess of three shifts or calendar days. An occupational disease that falls into any of the following categories requires the filing of a First Report of Injury:

(a) Chronic respiratory disease;

(b) Cancer;

(c) Pneumoconiosis, including but not limited to Coal worker's lung, Asbestosis, Silicosis, and Berylliosis;

(d) Nervous system diseases;

(e) Blood borne infectious, contagious diseases.

(3) Within ten days after notice or knowledge of a claim for benefits, including medical benefits only, that is denied for any reason.

(C) The insurer shall state whether liability is admitted or contested within 20 days after the date the employer's First Report of Injury is filed with the Division. If an Employer's First Report of Injury should have been filed with the Division, but wasn't, the insurer's statement concerning liability is considered to be due within 20 days from the date the Employer's First Report of Injury should have been filed. The date a First Report of Injury should have been filed with the Division is the last day it could have been timely filed in compliance with paragraph (B) above.

(D) The insurer shall state whether liability is admitted or contested within 20 days after the date the Division mails to the insurer a Worker's Claim for Compensation or Dependent's Notice and Claim for Compensation.

(E) No statement regarding liability is required unless a Workers' Compensation claim number is assigned or a First Report of Injury should have been filed pursuant to paragraph (B) of this rule. The Division cannot accept a statement regarding liability without a First Report of Injury, Worker's Claim for Compensation, or Dependents Notice and claim having been successfully filed and assigned a claim number.

(F) In the format required by the Director, each insurer shall submit a monthly summary report to the Division containing the following:

(1) Injuries to employees that result in no more than three days' or three shifts' loss of time from work, no permanent physical impairment, no fatality, or contraction of an occupational disease not listed in subsection (B) of the rule; and

(2) Exposures by employees to injurious substances, energy levels, or atmospheric conditions when the employer requires the use of methods or equipment designed to prevent such exposures and where such methods or equipment failed, was not properly used, or was not used at all.

5-3 INITIAL NOTICE TO CLAIMANT

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

5-4 MEDICAL REPORTS AND RECORDS

(A) Medical reports on claims that have been reported to the Division shall be filed with the Division under the following circumstances:

(1) When attached to an admission of liability form, or a petition to suspend benefits, or

(2) In connection with a request to the Division to determine the claimant's eligibility for vocational rehabilitation benefits or to review a vocational rehabilitation plan, or to review requests regarding the provision of vocational rehabilitation services, or

(3) When otherwise required by any other rule or the Act, or

(4) At the request of the director.

(5) A copy of every medical report not filed with the Division shall be exchanged with all parties within fifteen (15) working days of receipt.

(B) For claims which are not required to be reported to the Division, the parties shall exchange medical information immediately upon request for such information by any interested party. Five (5) working days is considered to be a reasonable time within which to exchange information.

(C) A party shall have 15 days from the date of mailing to complete, sign, and return a release of medical and/or other relevant information. If a written request for names and addresses of health care providers accompanies the medical release(s), a claimant shall also provide a list of names and addresses of health care providers reasonably necessary to evaluate/adjust the claim along with the completed and signed release(s). Medical information from health care providers who have treated the part(s) of the body or 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 generally be considered reasonable. If a party disputes that such request is reasonable or that information sought is reasonably necessary, that party may file a motion with the Office of Administrative Courts or schedule a prehearing conference. The request for and release of medical information as well as informal disclosures necessary to evaluate/adjust the claim are not considered discovery.

(D) A party shall have 15 days from the date of mailing to respond to a reasonable request for information regarding wages paid at the time of injury and for a reasonable time prior to the date of injury, and other relevant information necessary to determine the average weekly wage. Any dispute regarding such a request may be resolved by the Director or an Administrative Law Judge. The request for and exchange of information under this Rule 5-4(D) is not considered discovery.

5-5 ADMISSIONS OF LIABILITY

(A) When the final admission is predicated upon medical reports, such reports shall accompany the admission along with the worksheets or other evaluation information associated with an impairment rating. The admission shall specify and describe the insurer's position on the provision of medical benefits after MMI, as may be reasonable and necessary within the meaning of the Act. The admission shall make specific reference to the medical report by listing the physician's name and the date of the report.

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

(B) An admission filed for medical benefits only, shall include remarks outlining the basis for denial of

temporary and permanent disability benefits.

(C) Admissions shall be filed with supporting attachments immediately upon termination or reduction in the amount of compensation benefits. An admission shall be filed within 30 days of resumption or increase of benefits.

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

(1) Where the claimant is a state resident at the time of MMI:

(a) When an authorized treating physician providing primary care is not Level II accredited and has determined the claimant has reached MMI and has sustained any permanent impairment, such physician shall, within 20 days after the determination of MMI, refer the claimant to a Level II accredited physician for a medical impairment rating. If the referral is not timely made, the insurer shall refer the claimant to a Level II accredited physician for a medical impairment rating within 40 days after the determination of MMI.

(b) If the authorized treating physician determining MMI is Level II accredited, within 20 days after the determination of MMI, such physician shall determine the claimant's permanent impairment, if any.

(2) Where the claimant is not a state resident at the time of MMI:

(a) When an authorized treating physician providing primary care is not Level II accredited and has determined the claimant has reached MMI and has sustained any permanent impairment, within 20 days after the determination of MMI, such physician shall conduct tests to evaluate impairment and shall transmit to the insurer all test results and relevant medical information. Within 20 days of receipt of the medical information, the insurer shall appoint a Level II accredited physician to determine the claimant's medical impairment rating from the information that was transmitted.

(b) When the claimant chooses not to have the treating physician providing primary care conduct tests to evaluate impairment, or if the information is not transmitted in a timely manner, the insurer shall arrange and pay for the claimant to return to Colorado for examination, testing, and rating, at the expense of the insurer. The insurer shall provide to the claimant at least 20 days advance written notice of the date and time of the impairment rating examination, and a warning that refusal to return for examination may result in the loss of benefits. Such notification shall also include information identifying travel and accommodation arrangements.

(E) For those injuries required to be filed with the Division with dates of injury on or after July 1, 1991, and subject to §8-42-107(8), C.R.S., medical impairment:

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

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

(2) Request a Division Independent Medical Examination (IME) on the issue of medical impairment in accordance with Rule 11-3.

(F) Within 30 days after the date of mailing of the IME's report determining medical impairment the insurer shall either admit liability consistent with such report or file an application for hearing. This section does not pertain to IMEs rendered under §8-43-502, C.R.S.

(G) The insurer may modify an existing admission regarding medical impairment, whenever the medical impairment rating is changed pursuant to a binding IME, an IME selected in accordance with RULE 5-5(E); or an order. Any such modifications shall not affect an earlier award or admission as to monies previously paid.

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

(1) The time requirements as set forth in Rule 5-5(D) apply.

(2) Within 30 days after a determination of permanent impairment from an authorized Level II accredited physician is mailed or delivered, or a determination by the authorized treating physician providing primary care that there is no impairment is mailed or delivered, the insurer shall either:

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

(b) Set the matter for hearing at the Office of Administrative Courts.

(I) When an insurer files an admission admitting for a medical impairment, the insurer shall admit for the impairment rating in a whole number. If the impairment rating is reported with a decimal percentage, the insurer shall round up to the nearest whole number.

(J) This section (J) applies to claims with a date of injury on or after July 1, 2008. A carrier may not reduce a claimant's temporary total disability, temporary partial disability or medical benefits because of a prior injury, whether work-related or non work-related.

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

5-6 TIMELY PAYMENT OF COMPENSATION BENEFITS

(A) Benefits awarded by order are due on the date of the order. After all appeals have been exhausted or in cases where there have been no appeals, insurers shall pay benefits within thirty days of when the benefits are due. Any ongoing benefits shall be paid consistent with statute and rule.

(B) Temporary disability benefits awarded by admission are due on the date of the admission and the initial payment shall be paid so that the claimant receives the benefits not later than 5 calendar days after the date of the admission. Temporary total disability benefits are payable at least once every two weeks thereafter. In some instances an Employer's First Report of Injury and admission can be timely filed, but the first installment of compensation benefits will be paid more than 20 days after the insurer has notice or knowledge of the injury. So long as the filings are timely and benefits timely paid and for the entire period owed as of the date of the admission, the insurer will be considered in compliance.

(C) Permanent disability benefits awarded by admission are retroactive to the date of maximum medical improvement and shall be paid so that the claimant receives the benefits not later than 5

calendar days after the date of the admission. Subsequent permanent disability benefits shall be paid at least once every two weeks.

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

5-7 PERMANENT PARTIAL DISABILITY BENEFIT RATES

(A) Permanent partial disability benefits paid as compensation for a non-scheduled injury or illness which occurred on or after July 1, 1991, shall be paid at the temporary total disability rate, but not less than one hundred fifty dollars per week and not more than fifty percent of the state average weekly wage at the time of the injury.

(B) Scheduled impairment benefits shall be paid at the calculated rate pursuant to §8-42-107 (6) C.R.S.

(C) Where scheduled and non-scheduled injuries occurred resulting in impairment, the impairment benefits and the scheduled impairment benefit shall be paid concurrently.

5-8 ADMISSION FOR PERMANENT TOTAL DISABILITY BENEFITS

(A) An insurer shall file an admission of liability for permanent total disability benefits on a final admission of liability form prescribed by the Division.

(B) An insurer may terminate permanent total disability benefits without a hearing by filing an admission of liability form with all of the following attachments:

(1) A death certificate or written notice advising of the death of a claimant;

(2) A receipt or other proof substantiating payment of compensation to the claimant through the date of death; and

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

(a) Death benefits and

(b) If there are dependents, the unpaid portion of permanent total disability benefits the claimant would have received had s/he lived until receiving compensation at the regular rate for a period of six years.

5-9 REVISING ADMISSIONS

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

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

(C) This subsection applies to claimants with an open claim with dates of injury on or after July 1, 1991 and before August 5, 1998 with the most recent and valid Final Admission of Liability filed before September 1, 1999 to which a timely objection was filed by the claimant but no Division independent medical examination was held before September 1, 1999. The carrier, self-insured employer, or non-insured employer may file an amended Final Admission of Liability providing notice to the claimant of the requirement to mail a notice and proposal to select an independent medical examiner per §8-42-107.2 C.R.S. Failure to provide such notice by amended Final

Admission of Liability as indicated in this subsection shall preclude the carrier, self-insured employer or non-insured employer from asserting that the claimant failed to timely file a notice and proposal to select an independent medical examiner per §8-42-107.2 C.R.S. If the notice is provided by amended Final Admission of Liability the carrier, self-insured employer or non-insured employer is not precluded from subsequently raising any relevant equitable argument, such as waiver, laches or estoppel, regarding whether the notice and proposal was timely filed.

5-10 LUMP SUM PAYMENT OF AN AWARD

(A) For lump sum requests less than or equal to $10,000.00 for permanent partial disability awards for whole person or scheduled impairment, and where the injury or illness occurred on or after July 1, 1991, the following applies per §8-42-107 (8) C.R.S.:

(1) Lump sum payment of $10,000.00, or the remainder of the award, if less, shall automatically be paid, less discount, on the claimant's written request to the insurer. The insurer shall calculate the sum certain and issue payment taking applicable offsets (i.e., disability benefits, incarceration, garnishments) within ten (10) business days from the date of mailing of the request by the claimant.

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

(1) If the claimant is represented by counsel, a request for a lump sum payment of a portion or remaining benefits shall be made by submitting a Request for Lump Sum Payment form to the insurer and the Division, if the claimant has indicated that the admission will be accepted as filed, relative to permanent partial disability and maximum medical improvement. The claimant is not required to waive the right to pursue permanent total disability benefits as a condition to receiving the lump sum. Within ten (10) business days of the date the Request for Lump Sum Payment form was mailed, the insurer shall issue the payment and file the required benefit payment information with the Division, the claimant and the claimant's attorney.

(a) The insurer shall have ten (10) business days from the claimant's request to object to the payment of the lump sum. Prior to payment and within the same ten (10) day time period, the insurer shall submit the lump sum calculations to claimant, claimant's attorney and the Division providing the reason for the objection. Upon receipt of the form the Director shall make a determination on the lump sum request.

(b) The claimant shall have ten (10) business days from the date the payment or payment information was mailed to object to the accuracy of the payment by stating the basis for the objection, in writing, to the Division and insurer. Following receipt of the objection, the Director shall make a determination on the lump sum payment.

(c) The total of all lump sums may not exceed $60,000 per claim.

(2) If the claimant is not represented by counsel, a request for a lump sum payment of benefits shall be made by submitting a Request for Lump Sum Payment to the insurer and the Division if the clamant has indicated that the admission will be accepted as filed, relative to permanent partial disability and maximum medical improvement. The claimant is not required to waive the right to pursue permanent total disability benefits as a condition to receiving the lump sum. Within ten (10) business days of the date the Request for Lump Sum Payment form was mailed, the insurer shall file the required lump sum calculation information with the Division and the claimant.

(a) The claimant shall have ten (10) business days from the date of mailing of the benefit payment information provided by the insurer to object to the accuracy of this information. In the absence of an objection, a lump sum order issued by the Director will be based upon the information submitted.

(b) The total of all lump sums may not exceed $60,000 per claim.

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

5-11 FINAL PAYMENT OF COMPENSATION

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

(B) An insurer shall file a final payment notice in every compensable claim that was filed with the Division in which benefits were paid. The final payment notice shall reflect cumulative totals for all benefits paid and be submitted in the format required by the Division. A final payment notice shall be filed after all compensation issues have been resolved by final admission, final order or stipulation. The final payment notice shall be filed within 60 days after the claim is closed. For Permanent Total Claims, a Final Payment Notice shall be filed within 60 days after benefits have terminated. If a claim is reopened a final payment notice shall be filed within 60 days after the reopened claim closes.

5-12 RECEIPTS

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

5-13 INFORMATION ON CLAIMS ADJUSTING

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

(A) The name, address and telephone number of the administrator(s) responsible for its claims adjusting. This information shall be provided upon request or within 30 days of any change in the administrator(s) or the geographical location of the administrator(s). Notice of such change shall be provided in writing to both the claimant and the Division. Notice shall include the name, address, and toll-free telephone number of the claims administrator(s).

(B) A list of all claims established with the Division that are affected by the change described in the preceding paragraph. The list shall include claimant name, social security number, date of injury, insurer's claim number, and worker's compensation claim number, if available.

(C) Upon request of the Director, any or all records, including any insurer administrative policies or procedures, pertaining to the adjusting of Colorado Workers' Compensation claims. This authority shall not extend to personnel records of claims personnel. All documents shall remain confidential.

5-14 SURVEYS

(A) Within 30 days following closure of each claim that was reported to the Division, the insurer shall survey the claimant. If the claimant is deceased the survey shall be presented to the claimant's dependents, if there are such dependents. If two or more claims have been merged or consolidated, one survey may be presented.

(B) If the claimant has previously authorized the insurer to communicate through electronic transmission, the survey may be sent to the claimant electronically. Otherwise, the survey shall be mailed to the claimant. If mailed, along with the survey, the insurer shall provide a return postage pre-paid envelope for the claimant to use when returning the survey.

(C) The survey shall include the name of the insurer. The survey shall also have a space for the claimant to sign if communicated by mail. The survey shall include the following language: "This survey relates to your recent workers' compensation claim. We would like to find out how satisfied you are with the way your claim was handled." The survey shall include instructions as to how to return the completed survey to the insurer, and the sentence "Insurers and employers are prohibited by law from taking any disciplinary action or otherwise retaliating against those who respond to this survey." In addition, the survey shall set forth only the following questions:

(1) On a scale from 1 to 5, with 1 being the least satisfied and 5 being the most satisfied, please describe your satisfaction with the level of courtesy shown to you in relation to your workers' compensation claim.

1 2 3 4 5

(2) On a scale from 1 to 5, with 1 being the least satisfied and 5 being the most satisfied, please describe your satisfaction with how promptly you received medical care.

1 2 3 4 5

(3) On a scale from 1 to 5, with 1 being the least satisfied and 5 being the most satisfied, please describe your satisfaction with how promptly your claim was handled.

1 2 3 4 5

(4) On a scale from 1 to 5, with 1 being the least satisfied and 5 being the most satisfied, please describe your satisfaction with how quickly any disputes in your claim were resolved. If you did not have any disputes, please mark NA.

1 2 3 4 5 NA

(5) On a scale from 1 to 5, with 1 being the least satisfied and 5 being the most satisfied, please describe your overall satisfaction with the way your claim was handled.

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

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 regular employment, or

(3) a written report from an 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 to the claimant or copy of a written offer delivered to the claimant with a signed certificate indicating 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 copy of the written inquiry to the treating physician shall be provided to the claimant by the insurer or the insured at the time the authorized treating physician is asked to provide a statement on the claimant's capacity to perform the offered modified duty. The claimant is allowed a period of 3 business days to return to work in response to an offer of modified duty. The 3 business days runs from the date of receipt of the job offer. Such admission of liability shall admit for temporary partial disability benefits, if any, or

(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) A copy of a response form prescribed by the Division shall be mailed 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.

(C) 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.

(D) 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 forty (40) days from the date of the setting, because overpayment of benefits may result if the suspension, modification or termination is granted.

(E) When a hearing is continued at the request of the claimant, the 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 30 days from the date of the request for continuance.

(F) 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 certified copy of a mittimus, or other 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. and case law.

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 or pursuant to an order from the Director under 6-4(C), or an order of the Office of Administrative Courts following a hearing.

(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, Approval of Settlement Agreements and Petitions to Reopen

7-1 CLOSURE OF CLAIMS

(A) A claim may be closed by order, final admission, or pursuant to paragraph (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 to the claimant and the claimant's attorney if the claimant is represented. The letter must also 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 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, an MMI date should not be included.

B. A copy of the letter sent to the claimant must be attached to the final admission of liability.

C. If the claimant timely objects to a final admission of liability filed pursuant to this rule the insurer must withdraw the final admission and provide an opportunity for the claimant to attend a medical appointment(s).

(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) 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.

(2) 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 will determine whether the claim should remain open.

(D) An application for hearing or for a Division Independent Medical Examination without further action does not automatically constitute prosecution.

7-2 CONTENT AND APPROVAL OF SETTLEMENT AGREEMENTS

(A) When the parties enter into a full and final settlement of a claim, they shall use the appropriate form settlement agreement prescribed by the Division of Workers' Compensation. The parties shall not alter the prescribed form, except as set out in subparagraphs (1) and (2) below. Parties who are settling a claim for a fatality are not required to use the Division's prescribed form settlement agreement.

(1) When the claimant is represented by counsel the parties shall use the "Workers' Compensation Claim(s) Settlement Agreement: Represented Claimant." 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. The parties may attach other written agreements to the prescribed form and may refer to these agreements in Paragraph 9(B) of the settlement agreement. These other written agreements may include a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA), an agreement involving employment, or a waiver of bad faith. These other written agreements attached to a settlement agreement shall not be reviewed and approval of the settlement agreement does not constitute approval of any written agreement attached to the settlement agreement. If a represented claimant does not wish to waive the right to an appearance before the Director to review the terms of the agreement, a settlement proceeding shall be scheduled with the Division's Pre-Hearing Unit.

(2) When the claimant is unrepresented the parties shall use the "Pro Se (Unrepresented) Workers' Compensation Claim(s) Settlement Agreement." 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. The parties may attach a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) to the prescribed form and may refer to the WCMSA in Paragraph 9(B) of the settlement agreement. The parties shall not attach any other written agreement to the settlement agreement. A settlement proceeding shall be scheduled with the Division's Pre-Hearing Unit to consider approval of this agreement.

(B) The parties shall file the original, with all original signatures, plus two copies of a settlement agreement and a completed settlement routing sheet. 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. A proposed order in the form prescribed by the Division must also be provided.

(C) Parties requesting approval of a stipulation resolving one or more issues in dispute shall submit a motion for approval of joint stipulation to the Director or an ALJ and should not use the Division's prescribed form settlement agreement.

7-3 PETITIONS TO REOPEN

(A) A claimant or insurer may request to reopen a claim, pursuant to §8-43-303, C.R.S. by submitting a request to reopen on the Division prescribed form. The request must be provided to the other party and all attorneys of record. The request shall state the basis for reopening, and supporting documentation must accompany the request.

(1) If the other party agrees to reopen the claim the Division must be notified by the insurer in

writing or by admission.

(2) Upon request to reopen the requesting party may file an Application for Hearing with the Office of Administrative Courts.

(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.

7-4 SINGLE LIFE EXPECTANCY TABLE

Age	Life Expectancy	Age	Life Expectancy
0	82.4	38	45.6
1	81.6	39	44.6
2	80.6	40	43.6
3	79.7	41	42.7
4	78.7	42	41.7
5	77.7	43	40.7
6	76.7	44	39.8
7	75.8	45	38.8
8	74.8	46	37.9
9	73.8	47	37.0
10	72.8	48	36.0
11	71.8	49	35.1
12	70.8	50	34.2
13	69.9	51	33.3
14	68.9	52	32.3
15	67.9	53	31.4
16	66.9	54	30.5
17	66.0	55	29.6
18	65.0	56	28.7
19	64.0	57	27.9
20	63.0	58	27.0
21	62.1	59	26.1
22	61.1	60	25.2
23	60.1	61	24.4
24	59.1	62	23.5
25	58.2	63	22.7
26	57.2	64	21.8
27	56.2	65	21.0
28	55.3	66	20.2
29	54.3	67	19.4
30	53.3	68	18.6
31	52.4	69	17.8
32	51.4	70	17.0

33	50.4	71	16.3
34	49.4	72	15.5
35	48.5	73	14.8
36	47.5	74	14.1
37	46.5	75	13.4

Rule 8 Authorized Treating Physician / Independent Medical Examination

8-1 APPLICABILITY

(A) Employers who meet the criteria in §8-43-404(5)(a)(I)(B) or (II)(A), are exempt from the requirement to provide a list of at least two physicians or two corporate medical providers, or at least one physician and one corporate medical provider, when notified of an on the job injury. This Rule 8 does not apply to those exempt employers, except for the provisions of 8-2(B) and (C). If emergency care is provided an exempt employer may 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 as allowed by statute within seven (7) business days following the date the employer has notice of the injury. If an exempt employer does not properly designate an authorized treating physician as allowed by statute the injured worker may select a provider of the worker's choosing.

8-2 INITIAL REFERRAL

(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 in compliance with §8-43-404(5)(a)(I)(A), that for purposes of this Rule 8 will be referred to as the designated provider list, from which the injured worker may select a physician or corporate medical provider.

(1) The designated provider list can initially be provided to the injured worker verbally or through an effective pre-injury designation. If provided verbally or through a pre-injury designation, a written designated provider list shall be mailed, hand-delivered or furnished in some other verifiable manner to the injured worker within seven (7) business days following the date the employer has notice of the injury.

(2) The designated provider list shall state the insurer responsible for the claim, or that the employer is self-insured. In addition, the designated provider list shall include the name and contact information of the person, or a maximum of two people, that the employer and/or insurer designate as their representative(s). For purposes of this Rule 8, the person or people so designated shall be referred to as the respondents' representative(s).

(B) 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 paragraph (A) of this rule apply.

(C) 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 paragraph (A) of this rule.

(D) If the employer fails to comply with this Rule 8-2, the injured worker may select an authorized

treating physician of the worker's choosing.

8-3 INFORMATION PROVIDED BY DESIGNATED PROVIDERS

(A) An interested party to a particular claim, as referenced in §8-43-404(5)(a)(I)(A) and for purposes of this Rule 8-3, 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 8-3(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.

8-4 ON-SITE HEALTH CARE FACILITY

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

(B) To be a qualified on-site health care facility under this Rule 8-4, 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.

(C) 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(A)(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 physicians.

8-5 ONE-TIME CHANGE OF AUTHORIZED TREATING PHYSICIAN

(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. 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 8-4(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 8-4(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) An injured worker may obtain a one time change of physician by providing notice that meets the requirements set out in statute. If the insurer or employer believes the notice does not meet statutory requirements and does not want to recognize 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.

(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

In addition and separately from all the other provisions of this Rule 8, an injured worker may submit a written request to change physicians pursuant to 8-43-404(5)(a)(VI). The provisions of this Rule 8 relating to a one-time change of physician do not apply to a request for change of physician made under §8-43-404(5)(a)(VI).

8-8 INDEPENDENT MEDICAL EXAMINATIONS

The following rules apply when the employer or insurer causes an independent medical examination to be conducted pursuant to section 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.

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 anytime 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. In addition, the examining physician may add a $30 charge for all recorded examinations. The physician shall be entitled to charge $20.00 for each copy of the recording that is provided.

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

(C) 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 of $20.

(D) 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.

(E) 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.

(F) 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.

(G) 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.

(H) 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.

(I) 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. A $20 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.

(J) 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.

(K) 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.

(L) 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.

(M) 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 $20 payment 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.

(N) 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.

(O) If paragraph (N) 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) Interrogatories

(1) One set of 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, each of which shall consist of a single question or request.

(2) The responses to the interrogatories and production of documents shall be provided to all opposing parties within 20 days of mailing of the interrogatories and requests.

(3) The interrogatories and the requests for production of documents may not be submitted later than 40 days prior to hearing, except for expedited hearings.

(B) Depositions

(1) Depositions of a party may be taken upon written motion and order. 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; or

(c) All parties agree to the taking of a deposition.

(2) Depositions of other witnesses may be taken upon written motion, order, and written notice to all parties.

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

(D) Discovery, other than evidentiary depositions, shall be completed no later than 20 days prior to the hearing date, except for expedited hearings.

(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) All asserted privileges shall be accompanied by a privilege log with sufficient description to allow the other parties to assess the applicability of the privilege claims.

(G) 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.

(H) 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. Setting of a formal hearing on an expedited schedule shall constitute good cause. Good cause shall include but not be limited to an agreement of the parties .

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, C.R.S.

(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 a prehearing administrative law judge. Prehearing 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 motion, either written or oral. At least five days prior to the prehearing conference, the parties shall notify each other of the issues they intend to present to the prehearing administrative law judge. Additional time to respond to an issue raised at the prehearing conference may be requested by any party. It shall be within the discretion of the prehearing administrative law judge to determine if such additional time is necessary to protect the rights of the parties.

(2) 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 fax or hand-deliver any objections to the prehearing unit within 2 days after the date the prehearing conference is set. If the prehearing 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.

(3) At the time of the prehearing conference, each party may submit a prehearing statement setting forth a brief summary of the issues in dispute, the names of all witnesses each party intends to call, the estimated time each party will require to present testimony and evidence, and the status of settlement discussions. Each party may also submit any discovery or pre-trial motion.

(4) Any party to a claim may request, either in advance or on the date of the prehearing conference, that the prehearing conference be recorded electronically or by court reporter. 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 prepare a transcript. The cost of preparing such transcripts shall be paid by the requesting party directly to the vendor providing the service.

(5) The prehearing administrative law judge may require a party to provide available vocational, medical, hospital and employment records, or reports to the other parties.

(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 administrative law judge of the parties' mutual choice from the Office of Administrative Courts, 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 PLACE OF FILING

(A) All matters for the Director's determination shall be filed with the Division of Workers' Compensation, Customer Service Unit. Matters for the Director's determination include:

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

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

(3) Matters regarding claims handling or administration, for example, benefit distribution, petitions to modify, terminate or suspend temporary benefits, lump sum requests;

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

(5) Closure orders ;

(6) Matters involving uninsured employers;

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

(8) Applications for admission to the major medical or medical disaster funds;

(9) Settlement documents in which all parties are represented by counsel, unless settlement was finalized before an administrative law judge, in which case an administrative law judge may approve the settlement documents.

(B) To avoid duplication, and unnecessary expense to all parties and the Division of Workers' Compensation and the Office of Administrative Courts, copies of matters for the determination of the Director shall not be filed with the Office of Administrative Courts. However, copies of these documents may be filed if required as attachments, evidence submissions, and other instances to complete the record at the Office of Administrative Courts.

(C) All other motions and responses shall be filed, unless otherwise specifically ordered, with the Office of Administrative Courts office closest to the claimant's residence.

(D) To avoid duplication, and unnecessary expense to all parties and the Division of Workers' Compensation and the Office of Administrative Courts, copies of these motions and responses shall not be filed with the Division of Workers' Compensation. However, 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 .

9-4 CLAIM FILES

The file at the Division of Workers' Compensation will be retained at the Division and is not subject to subpoena for administrative hearings. Certified copies of any documents in the Division file can be tendered by a party to the Office of Administrative Courts and should 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. Absent extraordinary circumstances, no employee of the Division of Workers' Compensation should be expected or required to testify at a hearing.

9-5 TRUST DEPOSITS AND SURETY BONDS

(A) The Subsequent Injury Fund Unit of the Division of Workers' Compensation is designated as trustee for purposes of §8-43-408(2). C.R.S. When the provisions of §8-43-408, C.R.S. 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), C.R.S. 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

Two or more claims or applications may be consolidated for hearing or other purposes upon the order of a judge or the Director for good cause shown.

9-7 PENALTY PROCEDURES

A party requesting that the Director assess penalties shall file a motion with the Division of Workers' Compensation directed to the attention of the Director. If no response to the motion is filed the Director will issue an order to show cause. If necessary the Director may hold a hearing or may refer the matter for a hearing.

9-8 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. Any application for hearing, response, or other pleading filed at the Office of Administrative Courts by an attorney on behalf of a party shall be considered to be an entry of appearance at the Office of Administrative Courts.

(B) When a claim has closed, an attorney may withdraw by filing a substitution of counsel signed by both attorneys and sent to all parties, or 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 attorneys and sent to all parties. Otherwise, an attorney must request an order allowing withdrawal from the claim by filing a motion with the Office of Administrative Courts and including the required notice. The motion must be sent to the client and all parties. The notice must contain all 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 it is not pursued;

(4) The date scheduled for any future hearings, the dates by which any pleadings or briefs are to 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.

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 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 send a copy of the written statement to all parties. A timely and properly submitted written response will be added to the review packets.

(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 position in 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

These rules apply to parties and physicians participating in the workers' compensation IME program pursuant to the authority of the Workers' Compensation Act.

11-1 Qualifications

A physician who seeks appointment to the Division's medical review panel for the purpose of performing IME's under the authority of the Workers' Compensation Act, Title 8, Articles 40 through 47 of the Colorado Revised Statutes, shall make application and meet the following qualifications:

(A) Be licensed by the Board of Dental Examiners, the Board of Chiropractic Examiners, the Colorado Podiatry Board, the Board of Medical Examiners and board certified (or board eligible) by the American Board of Medical Specialties or the American Osteopathic Association or another organization acceptable to the Division;

(B) For determination of maximum medical improvement (MMI), have attained at least Level I accreditation and have 384 hours per year of direct patient care (excluding medical/legal evaluation); and

(C) For purposes of determining permanent impairment have attained Level II accreditation and either have 384 hours per year of direct patient care (excluding medical/legal evaluation) or demonstrated additional competency in the field of disability evaluation through certification by the American Board of Independent Medical Examiners or the American Academy of Disability Evaluation Physicians.

(D) Shall have a license which is current, active and unrestricted.

(E) A physician who has agreed to perform an IME as a result of negotiation and agreement by the parties, and who has not applied for appointment to the Division's IME panel, is not required to complete the application for appointment to the IME panel as set forth in section 11-2. However, such physician shall comply with all other qualifications and procedures governing the conduct of IME proceedings as established by this rule.

11-2 Appointment Procedures

The physician shall complete the Division application form, certify to and, upon approval of the application, comply with the following:

(A) Unless otherwise approved by both parties, or the Division, the physician shall conduct an IME no

earlier than 35 calendar days, nor later than 50 calendar days from the telephone call requesting an appointment;

(B) Within 20 calendar days of the examination submit the original report with all attachments to the Division and a copy to all parties;

(C) Decline a request to conduct an IME only on the basis of good cause shown, as determined by the Director;

(D) Comply with the Workers' Compensation Rules of Procedure;

(E) Conduct an IME pursuant to this section in an objective and impartial manner;

(F) Not refer any IME claimant to another physician for treatment or testing unless an essential test is required pursuant to section 11-4(A) of this rule;

(G) Not become the treating physician for the IME claimant, unless approved by the Director, ordered by an administrative law judge, or by both parties by written agreement;

(H) Not evaluate an IME claimant if the appearance of or 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. Further, a conflict may be presumed to exist when the IME physician and a physician that previously treated the claimant has a relationship which involves a direct or substantial financial interest. The following guidelines are to assist in determination of conflict or the appearance of a conflict:

(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 should be determined at the time the IME is being requested. Relationships in existence before or after the review will have no bearing, unless a direct and substantial interest is present at the time of the IME.

(3) 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 or the appearance of a conflict, absent the present existence of a direct or substantial financial interest.

(I) Not employ invasive diagnostic procedures unless approved as provided in 11-4 (A), below;

(J) Not substitute any other physician as the designated IME physician without written permission of the director;

(K) In order to assure fair and unbiased IME's, not engage in communication regarding the IME with any person other than Division staff, except under the following circumstances: the claimant during the IME examination, the requesting party when setting the appointment, by approval of the Director, both party written agreement, an order by an administrative law judge, by deposition or subpoena as approved by an administrative law judge;

(L) No later than 30 calendar days after the cancellation of an examination, refund to the paying party part or all of the fee paid by that party as may be required by these rules or by the Director.

(M) For each IME case assigned, address the following issues and make findings if relevant: maximum

medical improvement, permanent impairment, and apportionment of impairment. Also consider any issues presented on the “Application for IME” or as directed by an administrative law judge. If the IME is requested pursuant to §8-42-107(8)(b)(ii)(a-d), C.R.S., the requesting party shall clearly note such on the IME application form.

11-3 Requests for an IME:

(A) Application Process:

(1) Either party that disputes the determination of MMI or impairment made by an authorized treating physician in a workers’ compensation case may apply for an IME.

(2) Requirement to Negotiate: Prior to Division intervention, the parties must attempt to negotiate the selection of a physician to conduct the IME. Parties that have agreed upon a physician to conduct the IME shall schedule the appointment pursuant to section 11-2(A) of this rule and shall notify the Division on the IME application form. If despite the good faith efforts of the parties, an agreement that was reached fails, either party may apply to the Division for the selection of an IME physician, using the form required under 11-3(B), below, within 30 days of such failure.

(3) The requesting party shall submit an application for an IME according to 11-3(B), below. If the parties did not agree on the physician, the insurer shall notify the Division and the other party on a prescribed form regarding the failed negotiation within 30 calendar days of their failure to agree. The party disputing the determinations of the authorized treating physician, and seeking review of those determinations (“requesting party”) shall file an application for IME within 30 days of the date of the failure to agree upon an IME physician.

(4) Insurers are not designated the requesting party simply due to their obligation to submit the documents referenced above. The requesting party is the party disputing the determinations of the authorized treating physician and seeking review of those determinations. The requesting party must complete the application for IME.

(5) The parties may agree to limit the issues addressed in an IME exam. Such agreement shall be in writing, signed by both parties, and provided to the IME unit no later than five (5) days prior to the IME appointment date. An opinion from an IME examiner concerning MMI, impairment or apportionment in a case in which the parties agreed to limit such issue, is not entitled to any weight before an administrative law judge.

(B) Form Required: The prescribed form, "Application for a Division Independent Medical Examination" shall be used in all cases to request an IME. The Division requires that the party requesting the IME designate:

(1) The preferred geographic location for the IME examination;

(2) The body part(s) or medical conditions to be evaluated, including whether mental impairment shall be evaluated;

(3) Other physicians that have previously evaluated, treated, or are currently treating the claimant.

The requesting party shall certify that all parties and the Division have been sent the application form at the same time by the same means. Only the Division application form or a materially substantial equivalent duplication approved by the Division is acceptable.

(C) IME Physician Selection: If the parties are unable to agree upon a physician to conduct the IME, the Division will select via a revolving selection process a panel of three qualified physicians from its list of qualified physicians, from which one physician shall be designated to perform the IME. To obtain a pool of qualified physicians from which the Division shall make the selection of the three physician panel, the Division shall consider to the extent possible the criteria identified in the application for IME as set forth in section 11-3(B) of this rule. The Division will correlate the body parts or medical conditions on the IME application with the appropriate medical treatment guideline on the table designated in section 11-12. The three-physician panel will be comprised of physicians based on their accreditation to perform impairment ratings on the body part(s) and/or medical conditions designated by the requesting party on the IME application. At the time a physician applies to join the IME panel of physicians, he/she shall designate the body parts or medical conditions that he/she is willing and able to evaluate. Physicians electing not to perform impairment ratings on certain body parts or conditions shall not be included in any three-doctor panel where those body parts or conditions are listed on the IME application pursuant to section 11-3(B)(2).

(D) The Division will apply the same selection process for designation of the three-physician panel for injuries or conditions for which no Division medical treatment guideline exists.

(E) All potential candidate names will be kept confidential until the selection of the three physician panel is made. The Division will notify the parties in writing by mail or fax of the names and the medical specialties of the three physician panel within ten calendar days after receipt of the application. The physician names and related information will be listed on a form generated and provided by the Division.

(F) Requests for Summary Disclosure:

(1) Within five (5) business days of issuance of the three-physician list by the Division, a party may request the physicians on the list provide a summary disclosure concerning any business, financial, employment or advisory relationship with the insurer, self-insured employer or the claimant. Such request shall be submitted, in writing, to the Division IME Unit with a copy to the other party. If a request is submitted, the requirement to strike a name from the list as described in paragraph (G) below shall be held in abeyance until the disclosure process is completed.

(a) No requests for any other information regarding a physician's business, financial, employment or advisory relationships shall be granted under this rule.

(b) The parties may use the information provided on the summary disclosure forms to assist in the decision to strike a physician from the list as described in paragraph (G) below. The information shall not be used as a basis for the Division to remove a physician from the three-physician panel.

(2) In response to requests for summary disclosure concerning relationships with the insurer or self-insured employer, the physicians shall submit a completed Form WC 179 to the Division IME Unit within seven (7) business days of notice from the Division.

(a) A physician may choose to pre-submit a disclosure Form WC 179 to the Division IME Unit to be kept on file. If the form is on file the physician shall update the form within thirty (30) days of a material change and at least once a year.

(b) The Division IME Unit shall provide the completed forms to all parties.

(c) If a physician has not provided the required form to be kept on file and fails to provide the required form in a timely manner, the physician shall be removed

from the three-physician list and a substitute physician selected by the Division IME Unit. The substitute physician shall be notified of the request for a summary disclosure and the same seven (7) business day time period described in paragraph (2) above shall apply.

(3) In response to requests for summary disclosure concerning relationships with a claimant who is a party to the claim, the physicians shall submit a completed Form WC 180 to the Division IME Unit within seven (7) business days of notice from the Division.

(a) The Division notice will include the name of the claimant and a blank copy of Form WC 180.

(b) The Division IME Unit shall provide the completed forms to all parties.

(c) If a physician fails to provide the required form in a timely manner, the physician shall be removed from the three-physician list and a substitute physician selected by the Division IME Unit. The substitute physician shall be notified of the request for a summary disclosure and the same seven (7) business day time period described in paragraph (3) above shall apply.

(4) Nothing in this section prohibits an insurer, self-insured employer or a claimant from disclosing any business, employment, financial or advisory relationship they may have with any or all of the physicians on the list.

(5) Physicians who are "agreed-upon" to perform Division IMEs pursuant to the Notice & Proposal Process described in section 8-42-107.2(3)(a), are not required to comply with the provisions in this section (F).

(G) If no request for a summary disclosure as set out in paragraph (F) above is made, within seven (7) 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. If a request for a summary disclosure as set out in paragraph (F) above is made, within five (5) business days of the Division's issuance to the parties of the WC 179 and/or the WC 180 forms by the Division IME Unit, the requesting party shall strike one name and inform the other party and the Division. Within five (5) business days of receiving that information from the requesting party, the other party shall strike one of the two remaining physicians and inform the Division's IME Unit, with confirmation to the requesting party, of the name of the remaining physician. That information shall be provided to the Division via fax or telephone. The parties may exchange information under this rule via fax, e-mail or telephone.

Where no summary disclosure forms have been requested of the physicians, and if the Division is not notified of the selected physician within fifteen (15) business days of the date the Division issued the three-physician panel the Division shall randomly select one name from the three-physician list. If physicians' summary disclosure forms have been requested, and the Division is not notified of the selected physician within ten (10) business days from the date the Division provides the disclosure forms to the parties, the Division shall randomly select one name from the three-physician panel. If one party fails to timely strike a physician from the list, the other party shall notify the Division and at the same time provide to the Division the name of the physician that party wishes to strike. In that situation the Division will randomly select one name from the remaining two physicians. The Division shall confirm to the parties by telephone and/or in writing the name of the selected physician.

If the selected physician declines or is unable to perform the IME, 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.

Additionally, if a physician is removed from the three-physician panel for any reason other than having been struck by one of the parties, the Division will issue one replacement name using the same criteria and process set forth in section 11-3(C), above.

(H) When a physician is selected from the three-physician panel to perform the IME, the Division will remove his/her name from the revolving list of physicians for a period of time so that he/she is not available for assignment to another three-physician panel. This period of time may be adjusted by the Division as necessary to balance the mandate to reduce over utilization of individual physicians, yet ensure that an adequate pool of physicians is available in each geographic area. This procedure shall not preclude the parties from agreeing-upon such physicians to perform division IMEs.

(I) Appointment Date: The date of the examination shall be set in accordance with section 11-2(A). The requesting party shall call the IME physician within five (5) business days after providing and/or receiving notice of the final IME physician selection to schedule the examination, and shall immediately notify the Division and the opposing party by telephone, and confirm in writing, the date and time of the examination. Absent good cause as determined by the Director or an administrative law judge, failure to make the appointment and advise all parties within five (5) business days permits the opposing party, after notifying the Division of such failure, to either schedule the IME appointment or to request cancellation of the IME.

(J) Submission of Medical Records: The insurer shall concurrently provide to the IME physician and all other parties, a complete copy of all medical records in their possession pertaining to the subject injury, postmarked or hand-delivered no fewer than fourteen (14) calendar days prior to the IME examination. If the insurer or its representative fails to timely submit medical records to the designated IME physician, the claimant may request the Division cancel the IME; or the claimant may submit all medical records he/she has available no later than ten (10) calendar days prior to the IME examination; or as otherwise arranged by the Division with the IME physician. This rule does not prohibit the rescheduling of the IME. The defaulting party may supplement the records pursuant to section 11-3(L).

(K) Form/Content of Medical Records Package: Pertinent medical records shall include all medical reports and medical records reflecting the diagnosis and treatment of the claimant's work-related injury, and shall include available medical records regarding relevant pre-existing condition(s) or work-related injury(ies). The medical file shall be two-hole punched at the top center of each page and clipped at the top with paper fasteners. A dated cover sheet shall be included listing the claimant's name, IME physician's name, date and time of the appointment, and the workers' compensation number. The medical file shall be in chronological order and tabbed by year. It shall include a written summary of medical providers with the range of dates of treatment. Medical records not meeting these requirements shall be resubmitted to the IME physician and all other parties in the correct format within three (3) business days of notification by the Division. Failure to timely and properly resubmit such records may result in cancellation of the IME by the Director, at the cost of the submitting party. Penalties otherwise available under these rules and the Act may be determined by the Director.

Medical bills, adjustor notes, surveillance tapes, admissions, denials, vocational rehabilitation reports, non-treating case manager records or commentaries to the IME physician shall not be submitted without written agreement of all parties, order of an administrative law judge, or prior permission of the Division.

(L) Submission of Supplemental Medical Records: Supplemental medical records shall be prepared according to section 11-3(K), above, and may be mailed or hand-delivered by any party concurrently to the IME physician and all other parties no later than seven (7) calendar days prior to the IME examination.

(M) Depositions: Medical depositions may be submitted as part of the medical records package only

by written agreement of all parties or pursuant to an order issued by the director or an administrative law judge. The IME physician shall be reimbursed for time spent reviewing medical depositions at the rate set forth in Rule 18, Testimony Fees. The party submitting the medical deposition shall be responsible for payment of the additional fees.

(N) Interpreter: The claimant shall be responsible for notifying the insurer of the necessity for a language interpreter, a minimum of fourteen (14) calendar days before the examination. The paying party 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 IME physician.

(O) IME Proceedings Held in Abeyance: If a party files a motion involving a pending IME proceeding, the moving party shall provide a copy of the motion directly to the Division's IME Unit. The IME proceeding shall be held in abeyance until the Division IME Unit is notified of the disposition as provided in this rule. When the motion is disposed of by written order or other means, the moving party shall provide a copy of the order or other dispositive document to the Division's IME Unit

11-4 PAYMENTS/FEES: UNLESS THE PARTY REQUESTING THE IME IS DETERMINED INDIGENT PURSUANT TO SECTION 11-11 OF THIS RULE, THE FOLLOWING SHALL APPLY TO PAYMENTS AND FEES:

(A) The physician performing the IME shall receive from the requesting party a fee of $675 at least 10 calendar days prior to the scheduled examination. If the fee is not timely received the fee for the IME shall be $775. If the record review is unusually extensive or complex or involves multiple body parts and requires longer than an hour for review, the physician shall contact the Division and request additional payment. This request should be made no later than three calendar days prior to the IME examination. The Division will transmit the request to the requesting party. If the requesting party declines to pay, the IME physician shall complete the IME process to the best of his/her ability without expending the additional time on record review. If additional file review charges are approved, the physician shall bill at the rate set forth in Rule 18-6(G)(3). The same process described in this paragraph shall apply with regard to any clinical or diagnostic testing requested by physicians performing IMEs.

It is expected that a test essential under the AMA Guides, 3rd Edition (revised) or the Level II accreditation curriculum for an impairment rating to be rendered will have been performed prior to the IME. Routine tests necessary for a complete IME should be performed as part of the IME 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 IME, the physician performing the IME shall notify the Division, who will notify the parties. Unless extraordinary circumstances exist that result in an ALJ issuing a ruling to the contrary, the physician performing the IME will either perform the essential test or refer out the essential test for completion, and the insurer shall be responsible for paying for the essential test.

(B) An IME examination may be canceled only by the requesting party, or the Division, no later than three (3) business days prior to the examination. The non-canceling party may contact the Division to determine whether the IME may be rescheduled. If the IME is not timely canceled or the claimant fails to keep the IME appointment, or the medical records are not submitted in a timely manner, the IME physician shall be entitled to retain $250.00 from the total fee when the IME was requested by the defaulting party. If the fee has not yet been paid, or the party responsible for untimely cancellation is not the requesting party, the physician shall be entitled to collect from the defaulting party a $250.00 cancellation/penalty fee. The insurer may be entitled to offset the cancellation fee against any future permanent or temporary benefits if the claimant fails to appear for the IME examination without good cause as determined by the Director or an administrative law judge.

(C) Services rendered by an IME physician shall conclude upon acceptance by the Division of the final

IME report. An IME report is final for the purpose of this section 11-4(C) of this rule, when it includes the requested determination regarding MMI and/or final impairment rating worksheets. A party who seeks the presence of an IME physician as a witness at a proceeding for any purpose, by subpoena or otherwise, shall be responsible for payment to the IME physician pursuant to Rule 18, Testimony Fees.

11-5 Multiple Impairment Rating IMEs

Only one IME impairment rating per case shall be administered by the Division's IME Section, pursuant to §8-42-107 (8), C.R.S., unless otherwise directed by written agreement of the parties, by order of an administrative law judge or the Director, or by request of the originally designated impairment rating IME physician.

11-6 Communication with an IME Physician

(A) During the IME process, there shall be no communication allowed between the parties and the IME physician unless approved by the Director, or an administrative law judge. Any violation may result in cancellation of the IME.

(B) After acceptance by the Division of the final report, no communication with the IME physician shall be allowed by any party or their representative except under the following circumstances: approval by the Director, both party written agreement, an order by an administrative law judge, by deposition or subpoena as approved by an administrative law judge. The parties shall provide the Division IME section with copies of any correspondence permitted under this section with the IME physician. See section 11-4(D) for fee information.

11-7 IME Follow-Up

Sections of this Rule 11 apply to follow-up procedures, as appropriate. If a Level II IME physician determines a claimant has not reached MMI and recommends further treatment a follow-up IME examination shall to the extent possible be scheduled with the original IME physician. The party requesting the follow-up appointment shall provide written notification on a Division prescribed form or a substantially similar form of such request to the Division's IME section, with a copy to the other party.

A return visit for range of motion validation shall be considered a part of the initial IME. Absent agreement by both parties or an order from an administrative law judge, any additional fees required for repeat range of motion shall be paid by the party that requested the IME.

A new IME physician may be selected only if agreed upon by both parties. The parties shall have reached prior agreement on who shall pay the $675.00 to the new IME physician prior to the patient visit. Payment shall be made in accordance with the procedures set forth in section 11-4. Upon good cause shown, an administrative law judge may also order a new physician and designate which party shall pay the examination fee.

Absent both party agreement or an order from an administrative law judge, the party requesting the follow-up shall pay any additional examination expense according to the Relative Value for Physicians Fee Schedule, incorporated by reference in Rule 18, set forth in the RVP's Evaluation & Management Section.

99241 Follow-up for repeat Range of Motion measurements.

99242 Follow-up evaluation is within six months of the original evaluation.

99243 Follow-up for evaluation on cases that are older than six months and less than one year from the original evaluation.

Follow-up for evaluation on cases older than one year from the original evaluation. These follow-ups may be charged at the full fee of $675.00. Charges described above are allowed due to the need for additional history-taking. Any additional pertinent medical records may be submitted prior to the follow-up appointment in accordance with sections 11-3(I) and (J).

11-8 Removal of a Physician from the Medical Review Panel:

Complaints regarding an IME physician may be submitted to the Director or to the Medical Director. Upon request of the IME physician, or whenever the Director determines it is appropriate, a physician may be made temporarily inactive and not included in the revolving selection process. The Director, in consultation with the Medical Director, may permanently remove a physician from the medical review panel on the following grounds:

(1) A misrepresentation on the application for appointment to the panel;

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

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

(4) Any other reason for good cause as determined by the Director. After six months from the date of removal, a physician may apply to the director for reinstatement on the panel. The decision to return the physician to the panel is in the sole discretion of the Director.

11-9 Immunity

Members of the medical review panel and any person acting as a consultant, witness, or complainant shall be immune from liability in any civil action brought against said person for acts occurring while the person was acting as a panel member, consultant, witness, or complainant, respectively, if such person was acting in good faith within the scope of the respective capacity, made a reasonable effort to obtain the facts of the matter as to which action was taken, and acted in the reasonable belief that the action taken by such person was warranted by the facts. Such grant of immunity from liability is necessary to ensure that the purposes of the IME provisions are met and participating physicians can exercise their professional knowledge, skills and judgment.

11-10 Disputes

Disputes concerning the division IME process that arise in individual cases that cannot be resolved by agreement of the parties, may be taken to an administrative law judge for resolution.

11-11 Indigent Claimant

(A) When a claimant applying for an IME pursuant to section 11-3(A) of this Rule asserts indigence, this process shall be followed:

(1) At the same time the "Notice and Proposal to Select an Independent Medical Examiner" form is submitted, the claimant may also indicate on the form whether indigence is asserted.

(2) Within twenty (20) days following submission of the Notice and Proposal to Select an Independent Medical Examiner and statement asserting indigence, the claimant wishing to assert indigent status shall file an "Application for Indigent Determination (IME)" form at the Office of Administrative Courts, and provide a copy to the other parties. A blank Application for Indigent Determination (IME) form may be obtained at the Division of

Workers' Compensation Customer Service Unit, at the IME unit, on the Division's website, or at the Office of Administrative Courts.

(3) The IME process will not be held in abeyance during the pendency of indigent application except that an IME physician will not be selected by the Division until a determination is made as to whether the claimant is indigent.

(4) Within eight (8) days after the date of mailing of the Application for Indigent Determination (IME) 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.

(5) Within twenty (20) days after the Application for Indigent Determination (IME) is filed, an administrative law judge shall issue an order based on the written submissions determining whether or not the claimant is indigent for purposes of paying for the IME. A hearing will be held only if the administrative law judge determines that one is necessary because a timely submitted response raises genuine issues of disputed material fact that must be resolved. In the event no response is filed but an administrative law judge determines there is a lack of sufficient information in the Application for Indigent Determination (IME), the administrative law judge may hold a hearing to obtain additional information. Any such hearing shall be held as expeditiously as possible, and if a hearing is held a determination must be issued within thirty (30) days of the date of filing of the Application for Indigent Determination (IME).

(6) The determination regarding indigence shall be based on the claimant's financial status as of the date the Application for Indigent Determination (IME) is filed. In making the determination on the Application for Indigent Determination (IME), the ALJ shall apply the following standard. A person shall be found to be indigent only if income is at or below the eligibility guidelines with liquid assets of $1,500 or less; or, income is up to 25% above the eligibility guidelines, liquid assets equal $1,500 or less, and the claimant's monthly expenses equal or exceed monthly income; or, if "extraordinary circumstances" exist which merit a determination of indigence. The following definitions shall apply in making the determination:

INCOME ELIGIBILITY GUIDELINES

Family Size	Monthly Income Guidelines	Monthly Income Guideline plus 25%	Yearly Income Guideline
1	$1,128	$1,410	$13,538
2	$1,518	$1,897	$18,213
3	$1,907	$2,384	$22,888
4	$2,297	$2,871	$27,563
5	$2,686	$3,358	$32,238
6	$3,076	$3,845	$36,913
7	$3,466	$4,332	$41,588
8	$3,855	$4,819	$46,263

For family units with more than eight members, add $390 per month to "monthly income" or $4,675 per year to "yearly income" for each additional family member.

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

(b) Liquid assets include cash on hand or in accounts, stocks, bonds, certificates of deposit, equity and personal property or investments which could readily be converted into cash without jeopardizing the applicant's ability to maintain home and employment. "Liquid assets" exclude any equity in any vehicle which the injured worker or his/her family must use for essential transportation unless the ALJ makes an affirmative finding of fact that the worker is credit worthy, can borrow against the equity in this vehicle, and can afford to pay back a loan without compromising his/her needs for food, clothing, shelter, and transportation.

(c) Expenses for nonessential items such as cable television, club memberships, entertainment, dining out, alcohol, cigarettes, etc. shall not be included.

(d) "Extraordinary circumstances" are deemed to be those which cause extraordinary financial hardship by depriving the claimant of the ability to provide for basic necessities that cannot be deferred, such as food, shelter, clothing, utilities, and medical costs not covered by insurance.

(7) The administrative law judge shall provide the determination regarding indigence in writing to all the parties. The determination shall include discussion sufficient to explain the basis of determination.

(B) Payment for the IME

(1) If an Administrative Law Judge determines that the claimant is not indigent, the claimant shall be responsible for payment of the IME. The process for selection of the physician and completion of the IME shall be as set forth in this rule.

(2) If an Administrative Law Judge determines that the claimant is indigent, the insurer shall advance payment for the cost of the IME. Such a payment must be made to the doctor no later than ten (10) days prior to the date of the scheduled IME appointment. The insurer shall also pay for any additional costs as identified in sections 11-4(B), 11-4(C), and 11-7 of this Rule.

(3) The IME will proceed as set forth in section 11-3 of this Rule. The claimant shall be considered the requesting party.

(4) After a final order is issued, a final admission of liability is uncontested, or the parties have settled the case on a full and final basis, claimant shall reimburse the cost of the IME to the insurer or employer who paid initially. The obligation to reimburse the cost does not arise until a final order or order approving the settlement is issued. Any reimbursement shall be taken as an offset against permanent indemnity benefits.

11–12 TABLE OF DIAGNOSES OR MEDICAL CONDITIONS – INDEPENDENT MEDICAL EXAMINATIONS PROGRAM

Medical Treatment Guidelines – List of Specified Diagnoses or Conditions

Guideline	Conditions	Body Part or System	Accreditation Units	Specialty
Lower Extremity	Ankle Sprain/Fracture	Ankle	Lower Extremity	Fully Accredited Specialists (Level II) Limited-Accredited Specialists: Orthopedics Neurology/Neurosurgery Plastic Surgery Rheumatology
	Talar fracture			
	Calcaneal fractures			
	Midfoot (Lisfranc's) Fracture Dislocation			
	Metatarsal-Phalangeal, Tarsal-Metatarsal, and Interphalangeal Joint Arthropathy			
	Pilon Fracture			
	Puncture wounds of the foot			
	Achilles Tendon Injury/Rupture			
	Ankle Osteoarthropathy			
	Ankle or Subtalar Joint Dislocation			
	Heel Spur Syndrome/Plantar Fasciitis	Foot		
	Tarsal Tunnel Syndrome			
	Neuroma			
	Knee – Chondral Defects	Knee		
	Aggravated Osteoarthritis			
	Anterior Cruciate Ligament Injury			
	Posterior Cruciate Injuries			
	Meniscus Injury			
	Patellar Subluxation			
	Retropatellar Pain Syndrome			
	Tendonitis/Tenosynovitis			
	Bursitis of the Lower Extremity			
	Hip fracture	Hip		
	Acetabulum Fracture			
	Hamstring Tendon Rupture			
	Hip Dislocation			
	Trochanteric Fracture	Hip, leg, pelvis		
	Femur Fracture	Leg		
	Tibia Fracture	Pelvis		
	Pelvic Fracture	Leg Pelvis	Spine Lower Extremity	Fully Accredited Specialists (Level II) Limited-Accredited Specialists: Orthopedics Neurology/Neurosurgery Plastic Surgery Rheumatology

Guideline	Conditions	Body Part or System	Accreditation Units	Specialty
Cervical Spine Injury	Incomplete Spinal Cord Injury Syndrome: Anterior Cord Syndrome Brown-Sequard Syndrome Central Cord Syndrome Posterior Cord Syndrome	Cervical Spine	Neuro/Spine	Fully Accredited Specialists (Level II) Limited-Accredited Specialists: Orthopedics Neurology/Neurosurgery Plastic Surgery Rheumatology
	Soft Tissue Injury, Quebec Classification, Grades I-IV			
	Disc Herniation			
Low Back Pain	No diagnoses other than Low Back Pain given.	Lumbar Spine	Spine	Fully Accredited Specialists (Level II) Limited-Accredited Specialists: Orthopedics Neurology/Neurosurgery Plastic Surgery Rheumatology
Traumatic Brain Injury	Mild TBI (MTBI)	Head Skull Brain	Neuro	Fully Accredited Specialists (Level II) Limited-Accredited Specialists: Neurology/Neurosurgery Psychiatry
	Moderate-Severe TBI			
Cumulative Trauma Disorder	DeQuervain's Tenosynovitis	Arm	Upper Extremity	Fully Accredited Specialists (Level II) Limited-Accredited Specialists: Neurology/Neurosurgery Orthopedics Hand Surgery Plastic Surgery Rheumatology
	Extensor Tendinous Disorders			
	Flexor Tendinous Disorders			
	Lateral Epicondylitis			
	Medial Epicondylitis			
	Cubital tunnel syndrome			
	Hand-Arm Vibration Syndrome			
	Guyon Canal (Tunnel) Syndrome			
	Pronator Syndrome			
	Radial Tunnel Syndrome			
	Elbow Musculoskeletal Disorders (Epicondylitis)	Elbow		
	Wrist Tendonitis, including DeQuervain's Tenosynovitis	Wrist		
	Trigger Finger	Hand, finger		
	Upper Extremity Tendonitis or bursitis	Elbow, shoulder		

Guideline	Conditions	Body Part or System	Accreditation Units	Specialty
Chronic Pain Disorder	Chronic Pain	N/A	Not rated separately – refer to initial injury	
Reflex Sympathetic Dystrophy/Complex Regional Pain Syndrome	CRPS-I (RSD), Stages 1-3 CRPS-II (Causalgia)	Neurologic system; also match specialty to body part, e.g., upper/lower extremity	Neuro; also check to see if the initial injury requires rating	**All except**: Pulmonology Otolaryngology (ENT) Ophthalmology Cardiology
Occupational Carpal Tunnel Syndrome	Carpal Tunnel Syndrome	Hand Wrist	Upper Extremity	Fully Accredited Specialists (Level II) Limited-Accredited Specialists: Neurology/Neurosurgery Orthopedics Hand Surgery Plastic Surgery Rheumatology
Thoracic Outlet Syndrome	Definite Thoracic Outlet Syndrome Probable Thoracic Outlet Syndrome Possible Thoracic Outlet Syndrome	Thoracic spine Thoracic nerves	Neuro	Fully Accredited Specialists (Level II) Limited-Accredited Specialists: Neurology/Neurosurgery Cardiothoracic Surgery Orthopedics
Shoulder	Acromioclavicular Joint Sprains/Dislocations Adhesive Capsulation/Frozen Shoulder Disorders Bicipital Tendon Disorders Brachioplexus Injuries Bursitis of the Shoulder Impingement Syndrome Rotator Cuff Tear Rotator Cuff Tendinitis Shoulder Fractures Shoulder Instability	Shoulder	Upper Extremity (Spine if cervical spine involvement)	Fully Accredited Specialists (Level II) Limited-Accredited Specialists: Neurology/Neurosurgery Orthopedics Plastic Surgery Rheumatology

Other Conditions

Condition	Specialty	Body Part or System
Dermatological	Fully Accredited Specialists (Level II); Limited-Accredited Specialist: Dermatology	Skin
Ophthalmic	Fully Accredited Specialists (Level II); Limited-Accredited	Eye, visual system

	Specialist: Ophthalmology	
Ear, Nose & Throat deformities	Fully Accredited Specialists (Level II) Limited-Accredited Specialists: Allergist, Otolaryngology, Plastic surgery	Ear, nose & throat; deformities
Hearing or vestibular problems	Fully Accredited Specialists (Level II) Limited-Accredited Specialist: Otolaryngology	Ear, middle ear
Cardiac	Fully Accredited Specialists (Level II) Limited-Accredited Specialist: Cardiac Surgery	Heart, cardiopulmonary system
Allergies (not isolated to skin or lungs)	Fully Accredited Specialists (Level II) Limited-Accredited Specialists: Allergist, Otolaryngology	Sinus
Pulmonary	Fully Accredited Specialists (Level II) Limited-Accredited Specialists: Allergist, Pulmonology	Lungs, cardiopulmonary system
Hernia	Fully Accredited Specialists (Level II)	Gastrointestinal
Surgery	Go to specific condition and choose surgical specialty accordingly	N/A
Mental/ Psychological Disorders	Fully Accredited Specialists (Level II) Limited-Accredited Specialists: Psychiatry, Neurology/Neurosurgery	Mental/Behavioral

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.

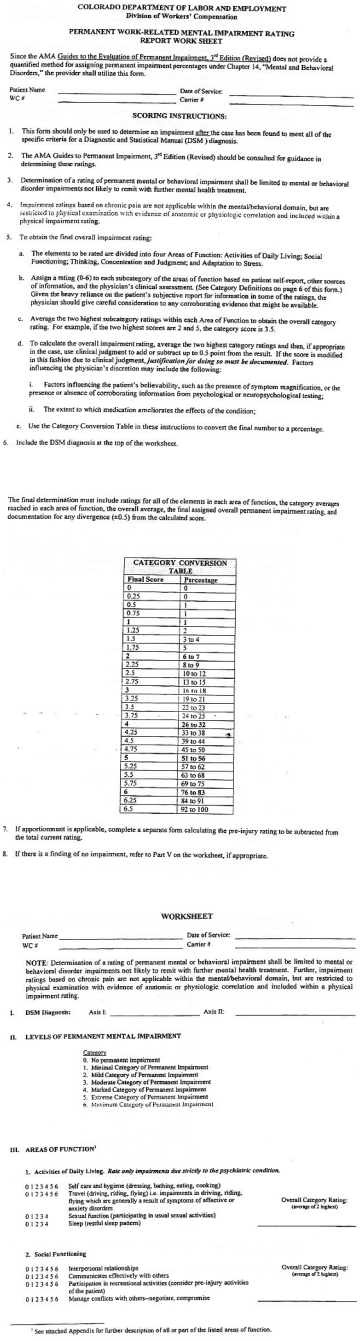
(3) Identify the appropriate joint impairment found on Table 17 of Chapter 3 of the AMA Guides.

(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 3, 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)

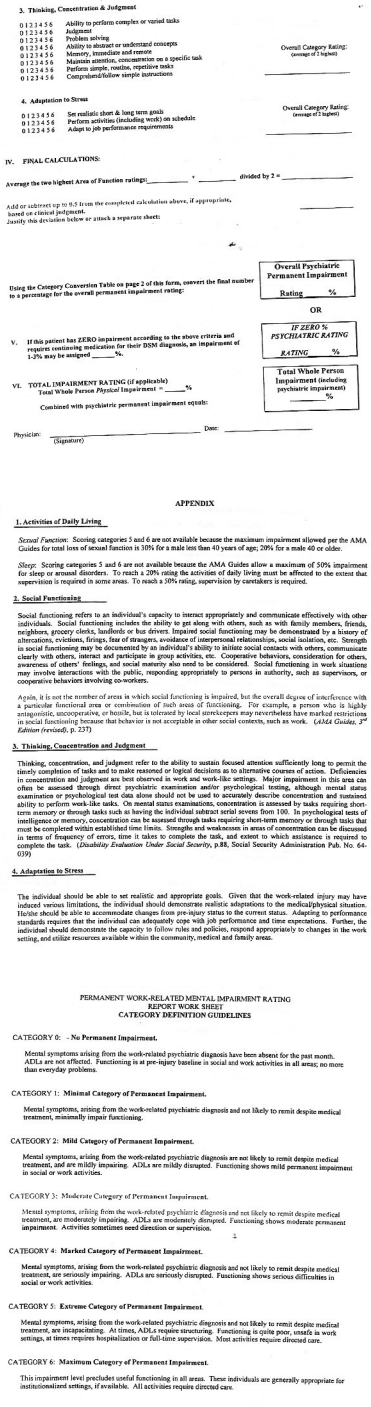
Overall Category Rating: (average of 2 highest) _____

2. Social Functioning

0 1 2 3 4 5 6 Interpersonal relationships
0 1 2 3 4 5 6 Communicate 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 9.5 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 30% 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 Accreditation of Physicians

13-1 STATEMENT OF BASIS AND PURPOSE

(A) This rule is promulgated to implement and establish procedures for the physicians accreditation program as set forth in statute, to provide physicians with an understanding of their administrative, legal and medical roles in the workers' compensation system. Accreditation requirements established shall apply to:

(1) Physicians who seek Level I accreditation under the Act; and

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

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

13-2 ACCREDITATION

(A) To obtain Level I or Level II Accreditation a physician must:

(1) be qualified under the act ;

(2) complete an application form prescribed by the Division and in Level II cases, indicate if full accreditation or limited accreditation is sought;

(3) attend a Division seminar and/or review the Division materials on the worker's compensation system; for Level II accreditation, this must include the *American Medical Association Guides to the Evaluation of Permanent Impairment* , Third Edition (Revised) , in effect as of July 1, 1991 (AMA Guides), and demonstrate an understanding of such materials by taking an examination administered by the Division; and

(4) certify agreement to comply with all Division rules, including but not limited to the medical treatment guidelines, permanent impairment rating guidelines and utilization standards adopted by the Director, and all relevant statutes.

(B) After paying the accreditation registration fee, a physician must satisfactorily complete the examination administered by the Division. If the physician does not exhibit sufficient knowledge upon completion of the examination on the third attempt, he or she shall be required to wait six months and pay a second registration fee before taking the examination again.

(C) Accreditation begins on the date the physician successfully completes the accreditation examination.

(D) Level II Accreditation expires on December 31 st of the third calendar year following the year the physician successfully completed the Level II Accreditation examinations; Level I Accreditation expires on July 31 st of the third year following the year the Level I applicant successfully completed the Level I Accreditation examination .

(E) For Level II Accreditation only:

(1) Full Accreditation: A qualified physician who satisfactorily completes the Level II Accreditation examination as determined and administe red by the Division shall be fully accredited to determine permanent impairment ratings on any work-related injury or illness.

(2) Limited Accreditation: A qualified physician who seeks Level II Accreditation in order to rate impairment only in connection with an area of medical specialty and who satisfactorily completes specified portions of the Level II examination as determined and administered by the Division shall receive limited accreditation to determine permanent impairment ratings on the corresponding sections of the AMA Guides.

13-3 RENEWAL OF ACCREDITATION

(A) The Division shall provide accredited physicians not less than sixty (60) days written notice of impending expiration of their accreditation.

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

(C) To renew accreditation, a qualified physician must:

(1) be qualified under the Act;

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

(3) complete the Division Reaccredidation Curriculum for Level I or Level II as appropriate;

(4) certify agreement to comply with all Division rules, including but not limited to the medical treatment guidelines, permanent impairment rating guidelines, and utilization standards adopted by the Director, and all relevant statutes.

(5) submit his/her first three (3) impairment rating reports to the Division following initial accreditation. Physicians who re-accredit must submit to the Division at least three (3) impairment reports during the three-year period following their reaccredidation. All such impairment rating reports may include Division Independent Medical Examination reports. A physician may not reaccredit until and unless this requirement is met, unless the physician has been unable to complete three impairment ratings during the three-year period for good cause as determined by the Director, and has met any other similar report requirement the Director may substitute. The purpose of providing these impairment reports is for education and 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 REVOCATION OF ACCREDITATION

(A) The Director, with input from the Medical Director, may initiate proceedings to revoke 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) a misrepresentation on the application for accreditation, or

(3) by final order of the Director in a proceeding held pursuant to §8-43-501, C.R.S., where the reviewing panel has unanimously recommended that accreditation be revoked.

(B) The severity of any sanctions taken under these rules shall reflect the character of the failure and the attendant circumstances.

(C) A proceeding to revoke 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 before an administrative law judge to revoke a physician's accreditation, the administrative law judge shall render proposed findings of fact and conclusions of law, and then 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 its legislative charge to assure appropriate and timely medical care at a reasonable cost, the Director (Director) of the Division of Workers' Compensation (Division) has promulgated these utilization standards, effective January 1, 2011. This rule defines the standard terminology, administrative procedures and dispute resolution procedures required to implement the Division's Medical Treatment Guidelines and Medical Fee Schedule. With respect to any matter arising under the Colorado Workers' Compensation Act and/or the Workers' Compensation Rules of Procedure

and to the extent not otherwise precluded by the laws of this state, all providers and payers shall use and comply with the provisions of the "Medical Treatment Guidelines," Rule 17, and the "Medical Fee Schedule," Rule 18, as incorporated and defined in the Workers' Compensation Rules of Procedure, 7 CCR 1101-3.

16-2 STANDARD TERMINOLOGY FOR RULES 16 AND 18

(A) Ambulatory Surgical Center (ASC) – licensed as an ambulatory surgery center by the Colorado Department of Public Health and Environment.

(B) Authorized Treating Provider (ATP) – may be any of the following:

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

(2) A health care provider to whom an authorized treating physician refers the injured worker for treatment, consultation, or impairment rating;

(3) A health care provider selected by the injured worker when the injured worker has the right to select a provider;

(4) A health care provider authorized by the employer when the employer has the right or obligation to make such an authorization;

(5) A health care 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) – any billed service, procedure, equipment or supply provided to an injured worker by a provider.

(D) Billing Party – a service provider or an injured worker who has incurred authorized medical costs.

(E) Certificate of Mailing – a signed and dated statement containing the names and mailing addresses of all persons receiving copies of attached or referenced document(s), certifying the documents were placed in the U.S. Mail, postage pre-paid, to those persons.

(F) Children’s Hospital – as identified and Medicare certified by the Colorado Department of Public Health and Environment.

(G) Convalescent Center – as licensed by the Colorado Department of Public Health and Environment.

(H) Critical Access Hospital (CAH) – as identified and Medicare certified by the Colorado Department of Public Health and Environment.

(I) Day – for the purpose of Rule 16, day is defined as a calendar day unless otherwise noted.

(J) Hospital – as identified and licensed by the Colorado Department of Public Health and Environment.

(K) Long-Term Care Facility – as identified and Medicare certified by the Colorado Department of Public Health and Environment

(L) Medical Fee Schedule – Division's Rule 18, its Exhibits, and the documents incorporated by reference in that rule.

(M) Medical Treatment Guidelines – the medical treatment guidelines as incorporated into Rule 17, "Medical Treatment Guidelines."

(N) Payer – an insurer, employer, or their designated agent(s) who is responsible for payment of medical expenses.

(O) Private Psychiatric Facilities – Licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

(P) Provider – a person or entity providing authorized health care service, whether involving treatment or not, to a worker in connection with work-related injury or occupational disease.

(Q) Rehabilitation Facilities – licensed as a rehabilitation hospital by the Colorado Department of Public Health and Environment.

(R) Rural Health Facility – as identified and Medicare certified by the Colorado Department of Public Health and Environment.

(S) Skilled Nursing Facility (SNF) – licensed as a skilled nursing facility by the Colorado Department of Public Health and Environment

(T) State Psychiatric Hospitals and State Mental Health Institutions – licensed as a psychiatric facility and operated by the state.

(U) "Supply et al." – any single supply, durable medical equipment (DME), orthotic, prosthesis, biologic, or single drug dose, for which the billed amount exceeds $500.00 and all implants.

(V) Veterans' Administration Medical Facilities – all medical facilities overseen by the Federal Veterans' Administration.

16-3 REQUIRED USE OF THE MEDICAL TREATMENT GUIDELINES AND PAYMENT FOR SERVICE

When an injury or occupational disease falls within the purview of Rule 17 "Medical Treatment Guidelines" and the date of injury occurs on or after July 1, 1991, providers and payers shall use the medical treatment guidelines, 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. Nor may a payer rely solely on its own internal guidelines or other standards for medical determination. When treatment exceeds or is outside of the Medical Treatment Guidelines, prior authorization is required. In all instances of contest appropriate processes to deny are required. Refer to applicable sections of Rule 16-9, 16-10 and/or 16-11.

16-4 REQUIRED USE OF THE MEDICAL FEE SCHEDULE

(A) When services provided to an injured worker fall within the purview of the medical fee schedule, all payers shall use the fee schedule to determine maximum allowable fees.

(B) All providers are required to report services in accordance with codes and standards in Rule 18 Medical Fee Schedule that accurately represent the services provided. The medical fee schedule sets the maximum allowable payment but the fee schedule does not limit the billing charges.

(C) The provider may be subject to penalties under the Workers' Compensation Act for inaccurate billing when the provider knew or should have known that the services billed were inaccurate, as determined by the Director or an administrative law judge..

16-5 RECOGNIZED HEALTH CARE PROVIDERS

(A) Physician and Non-Physician Providers

(1) For the purpose of this rule, recognized health care providers are divided into the major categories of "physician" and "non-physician". Recognized providers are defined as follows:

(a) "Physician providers" are those individuals who are licensed by the State of Colorado through one of the following state boards:

(1) Colorado State Board of Medical Examiners;

(2) Colorado State Board of Chiropractic Examiners;

(3) Colorado Podiatry Board; and

(4) Colorado State Board of Dental Examiners.

(b) "Non-physician providers" are those individuals who are registered or licensed by the State of Colorado Department of Regulatory Agencies, or certified by a national entity recognized by the State of Colorado as follows:

(1) Acupuncturist (LAc) – licensed by the Office of Acupuncturist Registration, Colorado Department of Regulatory Agencies;

(2) Advanced Practice Nurse – licensed by the Colorado State Board of Nursing; Advanced Practice Nurse Registry;

(3) Athletic Trainers (ATC) – certified by the Board of Certification, Inc. (BOC);

(4) Audiologist (AU.D., CCC-A) – certified by the American Speech Language-Hearing Association or board certified in audiology from the American Board of Audiology;

(5) Clinical Social Worker (LCSW) – licensed by the Colorado State Board of Social Work Examiners;

(6) Marriage and Family Therapist (LMFT) – licensed by the Colorado State Board of Marriage and Family Therapist Examiners;

(7) Massage Therapist (RMT) – registered as a massage therapist by the Colorado Department of Regulatory Agencies;

(8) Occupational Therapist (OTR) – registered by the Colorado Department of Regulatory Agencies as an occupational therapist certified by the National Board for Certification of Occupational Therapy;

(9) Optometrist (OD) – licensed by the Colorado State Board of Optometric Examiners;

(10) Orthopedic Technologist (OTC) – certified by the Board for Certification of Orthopedic Technologists, National Association of Orthopedic Technologists;

(11) Pharmacist – licensed by the Colorado State Board of Pharmacy;

(12) Physical Therapist (LPT) – licensed by the Colorado State Board of Physical Therapy;

(13) Physician Assistant (PA) – licensed by the Colorado State Board of Medical Examiners;

(14) Practical Nurse (LPN) – licensed by the Colorado State Board of Nursing;

(15) Professional Counselor (LPC) – licensed by the Colorado State Board of Professional Counselor Examiners;

(16) Psychologist (PsyD, PhD, EdD) – licensed by the Colorado State Board of Psychologist Examiners;

(17) Registered Nurse (RN) – licensed by the Colorado State Board of Nursing;

(18) Respiratory Therapist (RTL) – certified by the National Board of Respiratory Care and licensed by the Colorado Department Of Regulatory Agencies;

(19) Speech Language Pathologist (CCC-SLP) – certified by the American Speech Language-Hearing Association; and

(20) Surgical Technologist (CST) – certified under direction of the Association of Surgical Technologists.

(2) Upon request, health care providers must provide copies of license, registration, certification or evidence of health care training for billed services.

(3) Any provider not listed in Rule 16-5(A)(1)(a) or (b) must comply with Rule 16-9, Prior Authorization when providing all services.

(4) Referrals:

(a) A payer or employer shall not redirect or alter the scope of an authorized treating provider's referral to another provider for treatment or evaluation of a compensable injury. Any party who has concerns regarding a referral or its scope shall advise the other parties and providers involved.

(b) All non-physician providers must have a referral from an authorized treating physician. An authorized physician making the referral to any listed or unlisted non-physician provider is required to clarify any questions concerning the scope of the referral, prescription, or the reasonableness or necessity of the care.

(c) Any listed or non-listed non-physician provider is required to clarify any questions concerning the scope of the referral, prescription, or the reasonableness or necessity of the care with the referring authorized treating physician.

(5) Rule 18 Medical Fee Schedule applies to authorized services provided in relation to a specific workers' compensation case.

(B) Out-of-State Provider

(1) Injured Worker Relocated

(a) 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, should s/he relocate out-of-state, can be obtained from the payer.

(b) A change of provider must be made:

(1) Through referral by the injured worker's authorized provider; or

(2) In accordance with § 8-43-404 (5)(a), C.R.S.

(2) Injured Worker Referred

In the event an injured worker has not relocated out-of-state but is referred to an out-of-state provider for treatment or services not available within Colorado, the referring provider shall obtain prior authorization from the payer as set forth in Rule 16-9, Prior Authorization, and 16-10, Contest of a Request for Prior Authorization. The referring provider's written request for out-of-state treatment shall include the following information:

(a) Medical justification prepared by the referring provider;

(b) Written explanation as to why the requested treatment/services cannot be obtained within Colorado;

(c) Name, complete mailing address and telephone number of the out-of-state provider;

(d) Description of the treatment/services requested, including the estimated length of time and frequency of the treatment/service, and all associated medical expenses; and

(e) Out-of-state provider's qualifications to provide the requested treatment or services.

(3) The Colorado fee schedule should govern reimbursement for out-of-state providers.

16-6 HANDLING, PROCESSING AND PAYMENT OF MEDICAL BILLS

(A) Use of agents, including but not limited to PPO networks, bill review companies, third party administrators (TPAs) and case management companies, shall not relieve the employer or insurer from their legal responsibilities for compliance with these rules.

(B) Payment for billed services identified in the fee schedule shall not exceed those scheduled rates and fees, or the provider's actual billed charges, whichever is less.

(C) Payment for billed services not identified or identified but without established value in the fee schedule shall require prior authorization from the payer as set forth in Rule 16-9 Prior Authorization and Rule 16-10 Contest of a Request for Prior Authorization. Determination of the payment amount shall be made by the payer and reflect the complexity, time, level of training and expertise required to perform the service or procedure, but shall at no time exceed the amount billed. The methodology for determination of payment used by the payer shall be made available to the provider upon request. If the payer uses a usual and customary rate data base (UCR), the payer must specify the percentile used, the zip code used and the source of the data base. Rule 16-11, Payment of Medical Benefits, sets forth the procedures for contesting any portion of a bill.

If there are no reasonable methods to determine a fee, the payer shall pay the billed charges.

(D) Any payer contesting a provider's treatment shall follow the procedures as outlined under Rule 16-10 Contest of a Request For Prior Authorization or Rule 16-11 Payment of Medical Benefits.

(E) The payer should note that ICD-9 Supplementary Classification of External Causes of Injury and Poisoning codes (E-codes), when submitted, shall not be used to establish the work relatedness of an injury or treatment.

16-7 REQUIRED BILLING FORMS AND ACCOMPANYING DOCUMENTATION

(A) Providers may use electronic reproductions of any required form(s) referenced in this section; however, any such reproduction shall be an exact duplication of such form(s) in content and appearance. With the agreement of the payer, identifying information may be placed in the margin of the form.

(B) Required Billing Forms

All health care providers shall use only the following billing forms or electronically produced formats when billing for services:

(1) CMS (Centers for Medicare & Medicaid Services) 1500 (08-05) - shall be used by all providers billing for professional services, durable medical equipment (DME) and ambulance with the exception of those providers billing for dental services or procedures; hospitals are required to use the CMS 1500 (08-05) when billing for professional services. Health care providers shall provide their name and credentials in an appropriate box of the CMS 1500 (08-05).

(2) UB-04 - shall be used by all hospitals, hospital-based ambulance/air services, Children's Hospitals, CAHs, Veterans' Administration Facilities, home health and facilities meeting the definitions found in Rule 16-2 when billing for hospital services or any facility fees billed by any other provider, such as ASCs, except for urgent care which may use the CMS 1500 (08-05).

(3) American Dental Association's Dental Claim Form, Version 2006 shall be used by all providers billing for dental services or procedures.

(4) With the agreement of the payer, the ANSI ASC X12 (American National Standards Institute Accredited Standards Committee) or NCPDP (National Council For Prescription Drug Programs) electronic billing transaction containing the same information as in (1), (2) or (3) in this subsection may be used.

(C) Required Billing Codes

All billed services shall be itemized on the appropriate billing form as set forth in Rule 16-7(A) and (B), and shall include applicable billing codes and modifiers from the fee schedule. National provider identification (NPI) numbers are required for workers' compensation bills; providers who are not permitted to obtain NPI numbers are exempt from this requirement. When billing on a CMS 1500 (08-05), the NPI should be that of the rendering professional at the line level whenever possible.

(D) Inaccurate Billing Forms or Codes

Payment for any services not billed on the forms identified and/or not itemized as instructed in Rule 16-7(B) and (C), may be contested until the provider complies. However, when payment is

contested, the payer shall comply with the applicable provisions set forth in Rule 16-11 Payment of Medical Benefits.

(E) Accompanying Documentation

(1) Authorized treating physicians sign (or countersign) and submit to the payer, with their initial and final visit billings, a completed "Physician's Report of Workers' Compensation Injury" (Form WC164) specifying:

(a) The report type as "initial" when the injured worker has their initial visit with the authorized treating physician managing the total workers' compensation claim of the patient. Generally, this will be the designated or selected authorized treating physician. When applicable, the emergency room or urgent care authorized treating physician for this workers' compensation injury may also create a WC 164 initial report. Unless requested or prior authorized by the payer in a specific workers' compensation claim, no other authorized physician should complete and bill for the initial WC 164 form. This form shall include completion of items 1-7 and 10. Note that certain information in item 2 (such as Insurer Claim #) may be omitted if not known by the provider.

(b) The report type as "closing" when the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient determines the injured worker has reached maximum medical improvement (MMI) for all injuries or diseases covered under this workers' compensation claim, with or without a permanent impairment. The form requires the completion of items 1-5, 6.B, C, 7, 8 and 10. If the injured worker has sustained a permanent impairment, then item 9 must be completed also and the following additional information shall be attached to the bill at the time MMI is determined:

(1) All necessary permanent impairment rating reports when the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient is Level II Accredited; or

(2) Referral to a Level II Accredited physician requested to perform the permanent impairment rating when a rating is necessary and the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient is not determining the permanent impairment rating.

(c) At no charge, the physician shall supply the injured worker with one legible copy of all completed "Physician's Report of Workers' Compensation Injury" (WC164) forms at the time the form is completed.

(d) The provider shall submit to the payer the completed WC164 form as specified in Rule 16-7(E), no later than fourteen (14) days from the date of service.

(2) Providers, other than hospitals, shall provide the payer with all supporting documentation at the time of submission of the bill unless other agreements have been made between the payer and provider. This shall include copies of the examination, surgical, and/or treatment records.

(3) Hospital documentation shall be available to the payer upon request. Payers shall specify what portion of a hospital record is being requested. (For example, only the emergency

room (ER) chart notes, in-patient physician orders and chart notes, x-rays, pathology reports, etc.)

(4) In accordance with Rule 16-11, the payer may contest payment for billed services until the provider completes and submits the relevant required accompanying documentation as specified by Rule 16-7(E).

(F) Providers shall submit their bills for services rendered within one hundred twenty (120) days of the date of service or the bill may be denied unless extenuating circumstances exist. Extenuating circumstances may include but are not limited to delays in compensability being decided or the provider has not been informed where to send the bill.

16-8 REQUIRED MEDICAL RECORD DOCUMENTATION

(A) A treating provider shall maintain medical records for each injured worker when the provider intends to bill for the provided services.

(B) All medical records shall contain legible documentation substantiating the services billed. The documentation shall itemize each contact with the injured worker and shall detail at least the following information per contact or, at a minimum for cases where contact occurs more than once a week, be summarized once per week:

(1) Patient's name;

(2) Date of contact, office visit or treatment;

(3) Name and professional designation of person providing the billed service;

(4) Assessment or diagnosis of current condition with appropriate objective findings;

(5) Treatment status or patient’s functional response to current treatment;

(6) Treatment plan including specific therapy with time limits and measurable goals and detail of referrals;

(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; and

(8) All prior authorization(s) for payment received from the payer (i.e., who approved the prior authorization for payment, services authorized, dollar amount, length of time, etc.).

16-9 PRIOR AUTHORIZATION

(A) Prior authorization for payment shall be requested by the provider when:

(1) A prescribed service exceeds the recommended limitations set forth in the medical treatment guidelines;

(2) The medical treatment guidelines otherwise require prior authorization for that specific service;

(3) A prescribed service is identified within the medical fee schedule as requiring prior authorization for payment; or

(4) A prescribed service is not identified in the fee schedule as referenced in Rule 16-6(C).

(B) All prior authorization for a prescribed service or procedure may be granted immediately and without medical review. However, the payer shall respond to all providers requesting prior authorization within seven (7) business days from receipt of the provider's completed request as defined in Rule 16-9(E). The duty to respond to a provider's written request applies without regard for who transmitted the request.

(C) The payer, upon receipt of the "Employer's First Report of Injury" or a "Worker's Claim for Compensation," shall give written notice to the injured worker stating that the requirements for obtaining prior authorization for payment are available from the payer.

(D) The payer, unless they have previously notified said provider, shall give notice to the provider of these procedures for obtaining prior authorization for payment upon receipt of the initial bill from that provider.

(E) To complete a prior authorization request, the provider shall concurrently explain the medical necessity of the services requested and provide relevant supporting medical documentation. Supporting medical documentation is defined as documents used in the provider's decision-making process to substantiate the need for the requested service or procedure.

(F) To contest a request for prior authorization, the payer is required to comply with the provisions outlined in Rule 16-10.

(G) The Division recommends payers confirm in writing, to providers and all parties, when a request for prior authorization is approved.

(H) If, after the service was provided, the payer agrees the service provided was reasonable and necessary, lack of prior authorization for payment does not warrant denial of payment.

16-10 CONTEST OF A REQUEST FOR PRIOR AUTHORIZATION

(A) If the payer contests a request for prior authorization for non-medical reasons as defined under Rule 16-11(B)(1), the payer shall notify the provider and parties, in writing, of the basis for the contest within seven (7) business days from receipt of the provider's completed request as defined in Rule 16-9(E). A certificate of mailing of the written contest must be sent to the provider and parties.

If an ATP requests prior authorization and indicates in writing, including their reasoning and relevant documentation, that they believe the requested treatment is related to the admitted workers' compensation claim, the insurer cannot deny based solely on relatedness without a medical review as under Rule 16-10(B).

(B) If the payer is contesting a request for prior authorization for medical reasons, the payer shall, within seven (7) business days of the completed request:

(1) Have all the submitted documentation under Rule 16-9(E) reviewed by a physician or other health care professional, as defined in Rule 16-5(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review; and

(2) After reviewing all the submitted documentation, the reviewing provider may call the requesting provider to expedite communication and processing of prior authorization requests. However, the written contest or approval still needs to be completed within the specified seven (7) days under Rule 16-10(B).

(3) Furnish the provider and the parties with either a verbal or written approval, or a written contest that sets forth the following information:

(a) An explanation of the specific medical reasons for the contest, including the name and professional credentials of the person performing the medical review and a copy of the medical reviewer's opinion;

(b) The specific cite from the Division's Medical Treatment Guidelines exhibits to Rule 17, when applicable;

(c) Identification of the information deemed most likely to influence the reconsideration of the contest when applicable; and

(d) A certificate of mailing to the provider and parties.

(C) Prior Authorization Disputes

(1) The requesting party or provider shall have seven (7) business days from the date of the certificate of mailing on the written contest to provide a written response to the payer, including a certificate of mailing. The response is not considered a "special report" when prepared by the provider of the requested service.

(2) The payer shall have seven (7) business days from the date of the certificate of mailing of the response to issue a final decision, including a certificate of mailing to the provider and parties.

(3) In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.

(D) An urgent need for prior authorization of health care services, as recommended in writing by an authorized treating provider, shall be deemed good cause for an expedited hearing.

(E) Failure of the payer to timely comply in full with the requirements of Rule 16-10(A) or (B), shall be deemed authorization for payment of the requested treatment unless:

(1) a hearing is requested within the time prescribed for responding as set forth in Rule 16-10(A) or (B), and

(2) the requesting provider is notified that the request is being contested and the matter is going to hearing.

(F) Unreasonable delay or denial of prior authorization, as determined by the Director or an administrative law judge, may subject the payer to penalties under the Workers' Compensation Act.

16-11 PAYMENT OF MEDICAL BENEFITS

(A) Payer Requirements for Processing Medical Service Bills

(1) For every medical service bill submitted by a provider, the payer shall reply with a written notice or explanation of benefits. In those instances where the payer reimburses the exact billed amount, identification of the patient's name, the payer, the paid bill, the amount paid and the dates of service are required. If any adjustments are made then the payer's written notice shall include:

(a) Name of the injured worker or patient;

(b) Specific identifying information coordinating the notice with any payment instrument associated with the bill;

(c) Date(s) of service(s), if date(s) was(were) submitted on the bill;

(d) Payer's claim number and/or Division's workers' compensation claim number, if one has been created;

(e) Reference to the bill and each item of the bill;

(f) Notice that the billing party may resubmit the bill or corrected bill within sixty (60) days;

(g) For compensable services for a work-related injury or occupational disease the payer shall notify the billing provider that the injured worker shall not be balance-billed for services related to the work-related injury or occupational disease;

(h) Name of insurer with admitted, ordered or contested liability for the workers' compensation claim, when known;

(i) Name, address, e-mail (if any), phone number and fax of a person who has responsibility and authority to discuss and resolve disputes on the bill;

(j) Name and address of the employer, when known;

(k) If applicable, a statement that the payment is being held in abeyance because a relevant issue is being brought to hearing.

(2) The payer shall send the billing party written notice that complies with 16-11(A)(1) within thirty (30) days of receipt of the bill. Any notice that fails to include the required information set forth in 16-11(A)(1) is defective and does not satisfy the payer's 30-day notice requirements set forth in this section.

(3) Unless the payer provides timely and proper reasons as set forth by the provisions outlined in 16-11(B) - (D), all bills submitted by a provider are due and payable in accordance with the Medical Fee Schedule within thirty (30) days after receipt of the bill by the payer.

(4) 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 on for the discount. If no response is forthcoming within 30 days, the payer must pay the maximum fee schedule allowance or the billed charges, whichever is less.

(5) Date of receipt of the bill may be established by the payer's date stamp or electronic acknowledgement date; otherwise, receipt is presumed to occur three (3) business days after the date the bill was mailed to the payer's correct address.

(6) Unreasonable delay in processing payment or denial of payment of medical service bills, as determined by the Director or an administrative law judge, may subject the payer to penalties under the Workers' Compensation Act.

(7) If the payer fails to make timely payment of uncontested billed services, the billing party may report the incident to the Division's Carrier Practices Unit who may use it during an

audit.

(B) Process for Contesting Payment of Billed Services Based on Non-Medical Reasons

(1) Non-medical reasons are administrative issues. Examples of non-medical reasons for contesting payment include the following: no claim has been filed with the payer; compensability has not been established; the billed services are not related to the admitted injury; the provider is not authorized to treat; the insurance coverage is at issue; typographic, gender or date errors are in the bill; failure to submit any medical documentation at all; unrecognized CPT® code.

(2) If an ATP bills for medical services and indicates in writing, including their reasoning and relevant documentation, that they believe the medical services are related to the admitted WC claim, the payer cannot deny based solely on relatedness without a medical review as under Rule 16-11(C).

(3) In all cases where a billed service is contested for non-medical reasons, the payer shall send the billing party written notice of the contest within 30 days of receipt of the bill. The written notice shall include all of the notice requirements set forth in 16-11(A)(1) and shall also include:

(a) Date(s) of service(s) being contested, if date(s) was(were) submitted on the bill;

(b) If applicable, acknowledgement of specific uncontested and paid items submitted on the same bill as contested services;

(c) Reference to the bill and each item of the bill being contested; and

(d) Clear and persuasive reasons for contesting the payment of any item specific to that bill including the citing of appropriate statutes, rules and/or documents supporting the payer's reasons for contesting payment.

Any notice that fails to include the required information set forth in this section is defective and does not satisfy the notice requirement set forth in this section. Such defective notice shall not satisfy the payer's 30 day notice requirement set forth in this section.

(4) Prior to modifying a billed code, the payer must contact the billing provider and determine if the modified code is accurate.

(a) If the billing provider agrees with the payer, then the payer shall process the service with the agreed upon code and shall document on their explanation of benefits (EOB) the agreement with the provider. The EOB shall include the name of the person at the provider's office who made the agreement.

(b) If the provider is in disagreement, then the payer shall proceed according to Rule 16-11(B) or 16-11(C), as appropriate.

(5) If the payer agrees a service or procedure was reasonable and necessary, the provider's lack of prior authorization for payment does not warrant denial of liability for payment.

(C) Process for Contesting Payment of Billed Services Based on Medical Reasons

When contesting payment of billed services based on medical reasons, the payer shall:

(1) Have the bill and all supporting medical documentation under Rule 16-7(E) reviewed by a

physician or other health care professional as defined in Rule 16-5(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. After reviewing the supporting medical documentation, the reviewing provider may call the billing provider to expedite communication and timely processing of the contested or paid medical bill.

(2) In all cases where a billed service is contested for medical reasons, the payer shall send the provider and the parties written notice of the contest within thirty (30) days of receipt of the bill. The written notice shall include all of the notice requirements set forth in 16-11(A)(1) and shall also include:

(a) Date(s) of service(s) being contested, if date(s) was(were) submitted on the bill;

(b) If applicable, acknowledgement of specific uncontested and paid items submitted on the same bill as contested services;

(c) Reference to the bill and each item of the bill being contested;

(d) An explanation of the clear and persuasive medical reasons for the decision, including the name and professional credentials of the person performing the medical review and a copy of the medical reviewer's opinion;

(e) The specific cite from the Division's Medical Treatment Guidelines exhibits to Rule 17, when applicable; and

(f) Identification of the information deemed most likely to influence the reconsideration of the contest, when applicable.

Any notice that fails to include the required information set forth in this section is defective and does not satisfy the notice requirement set forth in this section. Such defective notice shall not satisfy the payer's 30-day notice requirement set forth in this section.

(D) Process for Ongoing Contest of Billed Services

(1) The billing party shall have sixty (60) days to respond to the payer's written notice under 16-11(A) – (C). The billing party's timely response must include:

(a) A copy of the original or corrected bill;

(b) A copy of the written notice or EOB received;

(c) A statement of the specific item(s) contested;

(d) Clear and persuasive supporting documentation or clear and persuasive reasons for the appeal; and

(e) Any available additional information requested in the payer's written notice.

(2) If the billing party responds timely and in compliance with Rule 16-11(D)(1), the payer shall:

(a) When contesting for medical reasons, have the bill and all supporting medical documentation and reasoning under 16-7(E) and, if applicable, 16-11(D)(1) reviewed by a physician or other health care professional as defined in Rule 16-5(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review.

After reviewing the provider's documentation and response, the reviewing provider may call the billing provider to expedite communication and timely processing of the contested or paid medical bill.

(b) When contesting for non-medical reasons, have the bill and all supporting medical documentation and reasoning under 16-7(E) and, if applicable, 16-11(D)(1) reviewed by a person who has knowledge of the bill. After reviewing the provider's documentation and response, the reviewing person may call the billing provider to expedite communication and timely processing of the contested or paid medical bill.

(3) If before or after conducting a review pursuant to 16-11(D)(2), the payer agrees with the billing party's response, the billed service is due and payable in accordance with the Medical Fee Schedule within thirty (30) days after receipt of the billing party's response. Date of receipt may be established by the payer's date stamp or electronic acknowledgement date; otherwise, receipt is presumed to occur three (3) business days after the date the response was mailed to the payer's correct address.

(4) After conducting a review pursuant to 16-11(D)(2), if there is still a dispute regarding the billed services, the payer shall send the billing party written notice of contest within thirty (30) days of receipt of the response. The written notice shall include all of the notice requirements set forth in 16-11(A)(1) and shall also include:

(a) Date(s) of service(s) being contested, if date(s) was(were) submitted by the provider;

(b) If applicable, acknowledgement of specific uncontested and paid items submitted on the same bill as contested services;

(c) Reference to the bill and each item of the bill being contested;

(d) An explanation of the clear and persuasive medical or non-medical reasons for the decision, including the name and professional credentials of the person performing the medical or non-medical review and a copy of the medical reviewer's opinion when the contest is over a medical reason; and

(e) The explanation shall include the citing of appropriate statutes, rules and/or documents supporting the payer's reasons for contesting payment.

Any notice that fails to include the required information set forth in this section is defective and does not satisfy the notice requirement set forth in this section. Such defective notice shall not satisfy the payer's 30-day notice requirement set forth in this section.

(5) In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.

(E) When seeking clarification or dispute resolution from the Division's Medical Policy Unit (MPU), the requesting party must provide:

(1) A copy of the bill with the contested codes and dates of services in dispute;

(2) A copy of the payer's explanation as to why the billed services are being contested; and

(3) A copy of any applicable medical record documentation.

The MPU will try to provide a written analysis and opinion to the parties regarding the appropriate application of the Medical Fee Schedule within thirty (30) days of receipt of the complete documentation and the written request for assistance; or as soon thereafter as possible.

(F) Retroactive review of Medical Bills

(1) All medical bills paid by a payer shall be considered final at twelve months after the date of the original explanation of benefits unless the provider is notified that:

(a) a hearing is requested within the twelve month period, or

(b) a request for utilization review has been filed pursuant to § 8-43-501.

(2) 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 or other health care professional as defined in Rule 16-5(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. The payer shall send the billing party written notice that shall include all of the notice requirements set forth in 16-11(A)(1) and shall also include:

(a) Reference to each item of the bill where payer seeks to recover overpayments; and

(b) Clear and persuasive medical reason(s) for seeking recovery of overpayment(s). The explanation shall include the citing of appropriate statutes, rules, and/or other documents supporting the payer's reason for seeking to recover overpayment; and

(c) Evidence that these payments were in fact made to the provider.

(3) 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 shall include all of the notice requirements set forth in 16-11(A)(1) and shall also include:

(a) Reference to each item of the bill where payer seeks to recover overpayments; and

(b) Clear and persuasive reason(s) for seeking recovery of overpayment(s). The explanation shall include the citing of appropriate statutes, rules, and/or other documents supporting the payer's reason for seeking to recover overpayment; and

(c) Evidence that these payments were in fact made to the provider.

(4) In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.

(G) 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 services that are then admitted or ordered as covered under the Workers' Compensation Act, the payer shall reimburse the injured worker for the amounts actually paid for authorized services within thirty (30) days after 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. Each request for a refund shall indicate the service provided and the date of service(s) involved.

(H) 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 Rule 16-11.

16-12 ONSITE REVIEW OF HOSPITAL OR OTHER MEDICAL CHARGES

(A) The payer may conduct a review of billed and non-billed hospital or medical facility charges related to a specific workers' compensation claim.

(B) The payer shall comply with the following procedures:

Within thirty (30) days of receipt of the billing, notify the hospital or other medical facility of its intent to conduct a review. Notification shall be in writing and shall set forth the following information:

(1) Name of the injured worker;

(2) Claim and/or hospital or other medical facility I.D. number associated with the injured worker's bill;

(3) An outline of the items to be reviewed; and

(4) If applicable, the name, address and telephone number of any person who has been designated by the payer to conduct the review (reviewer).

(C) The hospital or other medical facility shall comply with the following procedures:

(1) Allow the review to begin within thirty (30) days of the payer's notification;

(2) Upon receipt of the patient's signed release of information form, allow the reviewer access to all items identified on the injured worker's signed release of information form;

(3) Designate an individual(s) to serve as the primary liaison(s) between the hospital or other medical facility and the reviewer who will acquaint the reviewer with the documentation and charging practices of the hospital or other medical facility;

(4) Provide a written response to each of the preliminary review findings within ten (10) business days of receipt of those findings; and

(5) Participate in the exit conference in an effort to resolve discrepancies.

(D) The reviewer shall comply with the following procedures:

(1) Obtain from the injured worker a signed information release form;

(2) Negotiate the starting date for the review;

(3) Assign staff members who are familiar with medical terminology, general hospital or other medical facility charging and medical records documentation procedures or have a level of knowledge equivalent at least to that of an LPN;

(4) Establish the schedule for the review which shall include, at a minimum, the dates for the delivery of preliminary findings to the hospital or other medical facility, a 10 business day response period for the hospital or other medical facility, and the delivery of an itemized listing of discrepancies at an exit conference upon the completion of the review; and

(5) Provide the payer and hospital or other medical facility with a written summary of the review within twenty (20) business days of the exit conference.

Rule 17 Medical Treatment Guidelines

17-1. STATEMENT OF PURPOSE

(A) In an effort to comply with its legislative charge to assure appropriate medical care at a reasonable cost, the director of the Division has promulgated these "Medical Treatment Guidelines." This rule provides a system of evaluation and treatment guidelines for high cost or high frequency categories of occupational injury or disease to assure appropriate medical care at a reasonable cost.

(B) Pursuant to section 8-42-101(3)(a)(I), C.R.S., prior to July 1 of each year the Division Director shall review all medical treatment guidelines. Written comments which have been submitted by the public to the director or the Division's medical director will be considered during such reviews.

17-2. USE OF THE MEDICAL TREATMENT GUIDELINES

(A) All health care providers shall use the medical treatment guidelines adopted by the Division.

(B) Payers shall routinely and regularly review claims to ensure that care is consistent with the Division's medical treatment guidelines.

17-3. STANDARD TERMINOLOGY FOR THIS RULE

See Rule 16, Utilization Standards.

17-4. 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.

17-5. PROCEDURE FOR QUESTIONING CARE

(A) In cases where treatment falls within the purview of a medical treatment guideline, prior authorization for payment is unnecessary unless the guideline specifies otherwise, or Rule 16-9 (A)(I)-(4) apply.

(B) If prior authorization is required by the Medical Treatment Guidelines or a provider requests prior authorization then the procedure for contesting a request for prior authorization for payment is under Rule 16-10.

(C) The treatment guidelines set forth care that is generally considered reasonable for most injured workers. However, the Division recognizes that reasonable medical practice may include deviations from these guidelines, as individual cases dictate. For cases in which the provider requests care outside the guidelines the provider should follow the procedure for prior authorization in Rule 16-9.

(2) If the payer questions whether treatment is consistent with the medical treatment guidelines then the procedure for contesting payment of a billed service is covered under Rule 16-11 (B) and (C)

17-6. FAILURE TO COMPLY

See Rule 1, General Definitions and General Provisions

17-7. EXHIBITS TO RULE 17

(A) Exhibit 1 – Low Back Pain Medical Treatment Guidelines

(B) Exhibit 2 – Carpal Tunnel Syndrome Medical Treatment Guidelines

(C) Exhibit 3 – Thoracic Outlet Syndrome Medical Treatment Guidelines

(D) Exhibit 4 – Shoulder Injury Medical Treatment Guidelines

(E) Exhibit 5 – Cumulative Trauma Disorder Medical Treatment Guidelines

(F) Exhibit 6 – Lower Extremity Medical Treatment Guidelines

(G) Exhibit 7 – Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy Medical Treatment Guidelines

(H) Exhibit 8 – Cervical Spine Injury Medical Treatment Guidelines

(I) Exhibit 9 – Chronic Pain Disorder Medical Treatment Guidelines

(J) Exhibit 10 – Traumatic Brain Injury Medical Treatment Guidelines

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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 History link that appears above the text in 7 CCR 1101-3. To view versions effective 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 18: Exhibit 1.

History

[For history of this section, see Editor's Notes in the first section, 7 CCR 1101-3]