DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation

WORKERS' COMPENSATION RULES OF PROCEDURE

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

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

Emergency Rules

Section 1 – Authority

This emergency regulation is promulgated and adopted by the Director of the Division of Workers' Compensation pursuant to §8-47-107.

Section 2 – Scope and Purpose

The purpose of this emergency regulation is to establish the procedures for Workers' Compensation applicable during the state of emergency declared by the Governor due to COVID-19.

The Division finds, pursuant to § 24-4-103(6)(a), C.R.S., that immediate adoption of this regulation is imperatively necessary for the preservation of public health, safety, or welfare as ensuring operation of the workers' compensation system is imperative to preserve the health of the citizens of Colorado. Therefore, compliance with the requirements of § 24-4-103, C.R.S., would be contrary to the public interest.

As reported cases of COVID-19 increase, they place a significant strain upon medical resources. These emergency rules are being promulgated to increase access to telehealth services in order to assure injured workers maintain access to reasonable and necessary medical care while complying with physical distancing guidelines and mandates.

COVID-19-related actions to promote physical distancing have disrupted workers' ability to receive in-person care for their job-related injuries and illnesses. Continuity of care is essential to monitor the progress of recovery. Treatment delays impede recovery and may increase claims costs. Increasing reimbursement for remote services to levels equivalent to in-person care should promote use of these alternatives to in-office care.

This rule supersedes and replaces the emergency rules adopted on March 24 and March 31, 2020. The rules adopted on those dates are revoked.

Section 3 – Applicability

While in effect, this emergency rule applies to all entities subject to the Workers' Compensation Rules of Procedure. The emergency procedures specified in this rule supersede the applicable rules of procedure; however, the Workers' Compensation Rules of Procedure remain in full force and effect where not in conflict with this emergency rule.

Section 4 – Electronic Communications

All information submitted to the Division of Workers' Compensation must be submitted via electronic mail. Only ONE document per email message is permitted (ie one FA with attachments or one GA with Support for Return to Work). Multiple attachments will not be accepted.

The subject line must include (in this order): WC#, Claimant first and last name, and type of document (FA, GA, Petition, LS Request, MTC, MTN). The document included with the email must be named in the same format as the subject line.

The Certificate of Service should reflect the date it was emailed to the Division of Workers' Compensation.

I. Admissions

General Admissions, Final Admissions, Petitions to Modify, Terminate, or Suspend (WC54), Request for Lump Sum Payment (WC62) must be addressed to: cdle_dowc_filings@state.co.us

II. Motions to Close

Motions to close must be filed via electronic mail and include an electronic mail address for all parties (including represented claimants). Motions to close not accompanied by the required email addresses will be rejected. Motions to close must be sent to: cdle_dowc_filings@state.co.us.

III. All other motions

Motions (other than motions to close) and submissions for the Prehearing and Settlement Unit must be addressed to: cdle_dowc_prehearings@state.co.us. Motions must be accompanied by a proposed order in either .doc or .docx format.

IV. Disfigurement

Requests for determination of additional compensation for disfigurement based upon submission of photographs must be filed via email to: cdle_dowc_prehearings@state.co.us

Electronically submitted requests must be accompanied by the Division form and include in the body of the email the date the photographs were taken.

V. Rejections of Coverage

Rejections of coverage must be submitted by email to cdle_dowc_coverage@state.co.us. A paper copy of the form must be sent via certified mail within ninety (90) days of the electronic submission.

VI. All Other Communication

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

First Reports of Injury and Notices of Contest must be submitted via EDI.

Electronic submission via mechanisms other than those set forth herein requires advanced approval of the Division.

Section 5 – Utilization Procedures

The seven (7) day requirement for denial of a request for prior authorization in Rule 16-7(B) is extended to thirty-five days for requests relating to a procedure or treatment which is unavailable at the time of the request due to emergency restrictions on medical treatment enacted by the Governor and/or Colorado Department of Public Health and Environment in executive order D2020 009.

Section 6 – Telehealth

Parties are encouraged to utilize telehealth wherever medically appropriate. Place of service 02 – Telehealth is removed from place of service codes used with the RBRVS facility RVUs.

Maximum allowance is the non-facility RBRVS unit value for the CPT® code times the appropriate conversion factor. A 95 modifier must be appended to the appropriate CPT® code(s). An additional $5.00 transmission fee is not payable.

Section 7 – Duration

This emergency rule shall be in effect until October 13, 2020 unless continued, superseded or rescinded.

Rule 1 General Definitions and General Provisions

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

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

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

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

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

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

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

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

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

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

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

1-2 COMPUTATION OF TIME/DATE OF FILING

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

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

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

1-3 NOTARIZATION OF AUTHORIZATION FOR RELEASE OF INFORMATION

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

1-4 SERVICE OF DOCUMENTS

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

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

(C) Vocational reports for claims based upon an injury on or after July 2, 1987 at 4:16 p.m. shall not be filed with the Division except when requested by the Director, when attached to a final admission. If the claimant participates in a vocational evaluation, or if the insurer offers vocational services and the claimant accepts, written reports must be produced and should be produced within 30 days and a copy of every vocational report not filed with the Division shall be exchanged with all parties within 15 working days of receipt.

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

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

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

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

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

(4) state the purpose for reviewing the orders.

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

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

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

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

1-6 MEDIATION

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

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

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

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

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

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

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

Rule 2 Workers' Compensation Insurance Premium And Payroll Surcharges

2-1 SURCHARGE REQUIREMENTS FOR INSURANCE CARRIERS

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

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

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

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

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

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

2-2 SURCHARGE REQUIREMENTS FOR SELF-INSURED EMPLOYERS

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

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

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

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

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

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

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

2-3 SURCHARGE REQUIREMENTS FOR SELF-INSURANCE POOLS

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

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

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

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

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

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

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

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

2-4 SURCHARGE RATES

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

(A) The workers' compensation cash fund premium surcharge rate authorized by § 8-44-112(1)(a), shall be 1.35 percent of the amount of all premiums written as defined in section 2-1(b) or the premium equivalent amount established in section 2-2(b) of this rule.

(B) The additional assessment to fund the cost containment program authorized by § 8-44-112(1)(b)(i), shall be 0.00 percent of all premiums written, as defined in section 2-1(b). This assessment shall not be imposed on self-insured employers.

(C) The assessment to fund the subsequent injury fund authorized by § 8-46-102(2)(a)(i), and the major medical fund authorized by § 8-46-202 shall be 0.1 percent of all premiums written as defined in section 2-1(b) or the premium equivalent amount established in section 2-2(b) of this rule.

Rule 3 Insurance Coverage

3-1 REPORTING REQUIREMENTS FOR INSURANCE CARRIERS AND EMPLOYERS

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

(B) Every insurance carrier shall advise the Division, by filing with NCCI, notice of the issuance or renewal of insurance coverage within thirty (30) calendar days of the effective date of coverage.

(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 only as directed by the Division.

(C) All first reports of injury and notices of contest filed with the Division shall be transmitted electronically via electronic data interchange (EDI) or via the Division's internet filing process. First Reports of Injury and Notices of Contest cannot be submitted via electronic mail.

(D) 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.

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

5-2 FILING OF EMPLOYERS' FIRST REPORTS OF INJURY

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

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

(1) If an injury results in a fatality, or three or more employees are injured in the same accident, in addition to filing a first report, the Division customer service unit shall be notified via telephone within twenty four (24) hours of notice of such an occurrence.

(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 any 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) A statement regarding liability is required for any claim in which a division-issued workers' compensation claim number is assigned or a First Report of Injury should have been filed pursuant to paragraph (B) of this rule. A statement regarding liability shall not be filed without a First Report of Injury, Worker's Claim for Compensation, or Dependents Notice and claim having been successfully filed and assigned a workers' compensation claim number. A first report of injury must be filed prior to a notice of contest being accepted by the division.

(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) business days of receipt. A claimant may opt to not receive copies of medical reports from the insurer under this section by providing written notice to the insurer. Such notice may be revoked by the claimant in writing at any time.

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

(C) A party shall have 15 days from the date of mailing to complete, sign, and return a release of medical and/or other relevant information. If a written request for names and addresses of health care providers accompanies the medical release(s), a claimant shall also provide a list of names and addresses of health care providers reasonably necessary to evaluate/adjust the claim along with the completed and signed release(s). Medical information from health care providers who have treated the part(s) of the body or conditions(s) alleged by the claimant to be related to the claim, during the period five years before the date of injury and thereafter through the date of the request, will be presumed reasonable. Any request for information in excess of the presumption contained in this rule shall include a notice that the insurer is requesting information in excess of what is presumed reasonable and that providing the information is not required. If a party disputes that a request within the presumption is reasonable or that information sought is reasonably necessary, that party may file a motion with the Office of Administrative Courts or schedule a prehearing conference. Requests for release of medical information as well as informal disclosures necessary to evaluate/adjust the claim are not considered discovery

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

5-5 ADMISSIONS OF LIABILITY

(A) When the final admission is predicated upon medical reports, a completed physician's report of workers' compensation injury form, a narrative report and appropriate worksheets shall accompany the admission.

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

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

(3) For claims reported to the division in which only medical benefits have been paid and no permanent impairment has been assigned, the attachment of a narrative report and appropriate worksheets is required only in cases where such documents are supplied by the physician concurrently with the physician's report of workers' compensation injury form.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) In cases involving only a scheduled impairment, an application for hearing or final admission may be filed without a division independent medical examination.

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

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

(F) Within 20 days after the date of mailing of the division's notice of receipt of the division independent medical examiner's report the insurer shall either admit liability consistent with such report or file an application for hearing. This section does not pertain to IMEs rendered under § 8-43-502, C.R.S.

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

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

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

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 five (5) calendar days after the date of the admission. Temporary total disability benefits are payable at least once every two weeks thereafter from the date of the admission. 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. When benefits are continuing, the payment shall include all benefits which are due as of the date payment is actually issued.

(C) Permanent impairment benefits awarded by admission are retroactive to the date of maximum medical improvement and shall be paid so that the claimant receives the benefits not later than five (5) calendar days after the date of the admission. Subsequent permanent disability benefits shall be paid at least once every two weeks from the date of the admission. When benefits are continuing, the payment shall include all benefits which are due as of the date payment is actually issued.

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

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

5-7 PERMANENT PARTIAL DISABILITY BENEFIT RATES

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

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

(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; and

(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 FINAL ADMISSIONS

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

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

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

5-10 LUMP SUM PAYMENT OF AN AWARD

(A) For lump sum requests less than or equal to $10,000.00 for permanent partial disability awards for whole person or scheduled impairment, and where the injury or illness occurred on or after July 1, 1991, the following applies per § 8-42-107.2 C.R.S:

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

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

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

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

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

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

(2) If the claimant is not represented by counsel, a request for a lump sum payment of benefits shall be made by submitting a Request for Lump Sum Payment to the insurer and the Division if the claimant has indicated that the admission will be accepted as filed, relative to permanent partial disability and maximum medical improvement. The claimant is not required to waive the right to pursue permanent total disability benefits as a condition to receiving the lump sum. Within ten (10) 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 issued per claim may not exceed the amount set forth in the annual maximum benefit order in effect on the date the lump sum is requested.

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

5-11 DOCUMENTATION OF APPORTIONMENT

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

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

5-12 RECEIPTS

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

5-13 INFORMATION ON CLAIMS ADJUSTING

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

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

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

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

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

5-14 CORRESPONDENCE FROM THE DIVISION

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

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

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

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

5-15 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 the claimant has not returned to work at full wages, 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) A written offer of modified duty may only be used to terminate benefits pursuant to this subsection if:

(i) A copy of the written inquiry to the treating physician is provided to the claimant by the insurer or 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; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) 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 sixty (60) 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 thirty (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 document issued by a court of criminal jurisdiction, which establishes that the claimant is confined in a jail, prison, or any department of corrections facility as a result of a criminal conviction.

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

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

6-8 FAILURE TO COMPLY WITH REQUIREMENTS OF RULE 6

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

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

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

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

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

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

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

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

Rule 7 Closure of Claims and Petitions to Reopen

7-1 CLOSURE OF CLAIMS

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

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

(1) Is not receiving temporary disability benefits; and

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

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

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

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

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

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

(1) The request to close the claim shall include a separate, properly captioned proposed order to show cause and prepared certificate of mailing, along with addressed, stamped envelopes for the claimant, insurer and each attorney of record who has entered an appearance in the case. Requests may not be submitted via electronic mail.

(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 may determine whether the claim should remain open. An application for hearing or for a division independent medical examination without further action (i.e., setting and attending a hearing or a division independent medical examination) does not automatically constitute prosecution.

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

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

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

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

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

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

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

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

7-2 PETITIONS TO REOPEN

(A) A claimant or insurer may request to reopen a claim, pursuant to §8-43-303, C.R.S. by 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 shall be notified by the insurer by the filing of an admission.

(2) The requesting party may file an Application for Hearing on the issue of reopening with the Office of Administrative Courts pursuant to §8-43-303, C.R.S.

(3) If the claim is reopened pursuant to an order, the insurer shall file an admission consistent with the order within 30 days of the order becoming final.

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

7-3 SINGLE LIFE EXPECTANCY TABLE EFFECTIVE JULY 1, 2018.

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

Rule 8 AUTHORIZED TREATING PHYSICIAN AND INDEPENDENT MEDICAL EXAMS

8-1 APPLICABILITY

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

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

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

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

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

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

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

8-2 DESIGNATED PROVIDER LIST

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

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

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

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

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

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

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

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

8-3 EMERGENCY DESIGNATION

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

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

8-4 INFORMATION PROVIDED BY DESIGNATED PROVIDERS

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

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

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

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

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

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

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

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

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

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

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

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

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

8-6 TRANSFER OF MEDICAL CARE

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

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

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

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

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

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

8-8 INDEPENDENT MEDICAL EXAMINATIONS

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

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

8-9 NOTICE TO CLAIMANT

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

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

8-10 AUDIO RECORDING AND FEES

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

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

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

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

8-11 PROCESS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8-12 MAINTENANCE OF THE RECORDINGS

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

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

8-13 DISPUTES

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

Rule 9 Division of Workers' Compensation Dispute Resolution

9-1 DISCOVERY

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

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

(B) Interrogatories and requests for production

(1) 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.

(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 60 days prior to hearing, except for expedited hearings.

(C) Depositions

(1) Depositions may be taken upon written motion and order, or by written consent of the parties.

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

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

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

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

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

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

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

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

(F) 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.

(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.

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

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

(a) Issues added more than two (2) business days after the setting may be heard at the discretion of the prehearing administrative law judge.

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

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

(a) A party objecting to the setting of a prehearing conference or refusing to participate in the conference shall e-mail, fax or hand-deliver any objections to the prehearing unit within 2 business days following 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.

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

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

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

9-3 MOTIONS

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

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

(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 and lump sum requests;

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

(5) Closure orders;

(6) Matters involving uninsured employers;

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

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

(9) Disputes regarding medical payments.

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

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

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

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

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

(G) Motions filed for consideration by a prehearing administrative law judge may be submitted via electronic mail.

9-4 PRIVILEGES AND PRIVILEGE LOGS

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

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

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

2. The author and recipient of the item;

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

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

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

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

9-5 TRUST DEPOSITS AND SURETY BONDS

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

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

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

9-6 CONSOLIDATION AND MERGER OF CLAIMS

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

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

(C) No motion will be required in instances where a duplicate claim has been created as the result of a typographical error in the claimant's social security number. When duplicate claims exist as a result of such an error, the claims may be merged upon written request to the Division with copies to all parties identifying the typographical error and supplying the correct information.

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 which states with specificity the grounds upon which penalties are being sought and includes all evidence upon which the requesting party is basing the request. If no response to the motion is filed the Director may issue an order to show cause why penalties should not be imposed. Failure to respond to the order to show cause may be deemed a confession of the facts alleged in the motion and a waiver of the right to be heard in response to the request for penalties.

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.

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

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

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

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

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

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

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

9-9 SETTLEMENT PROCEDURES

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

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

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

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

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

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

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

(H) 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.

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

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

9-10 CLAIM FILES

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

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

9-11 DISFIGUREMENT AWARD (PHOTO)

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

(B) Requests shall be accompanied by at least one photograph, clearly showing the disfigurement, taken after the injured worker has been placed at maximum medical improvement or at least six months after the disfiguring event.

(C) The back of each photograph shall be signed and dated by the injured worker. The signature shall certify the photographs are a true and accurate representation of the disfigurement at the time the request is being made.

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

Rule 10 Medical Utilization Review

10-1 REQUESTS FOR UTILIZATION REVIEW

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

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

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

10-2 FILING A REQUEST FOR UTILIZATION REVIEW

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

(1) completed and signed Division prescribed request form.

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

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

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

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

(1) A table of contents;

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

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

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

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

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

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

(3) The following sections:

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

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

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

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

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

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

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

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

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

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

10-3 OFFICIAL NOTIFICATION OF UTILIZATION REVIEW

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

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

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

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

10-4 ADDING MEDICAL RECORDS TO THE UTILIZATION REVIEW FILE

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

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

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

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

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

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

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

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

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

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

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

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

10-5 Selection of Utilization Review Committee Members

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

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

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

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

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

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

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

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

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

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

(F) Members of UR Committees shall not review any material other than what is provided by the Division, and shall not engage in communication regarding the Utilization Review with any person other than Division staff, except under the following circumstances: by approval of the Director; by written agreement of the parties to the case, including the provider under review; the provider under review and the parties to the case are strictly prohibited from having any communication with the members of the UR committee while the review is pending.

10-6 COMPOSITION OF UTILIZATION REVIEW COMMITTEES

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

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

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

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

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

10-7 RESPONSIBILITIES OF UTILIZATION REVIEW COMMITTEE MEMBERS

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

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

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

10-8 CHANGE OF MEDICAL PROVIDER

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

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

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

10-9 UTILIZATION REVIEW APPEALS

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

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

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

Rule 11 Division Independent Medical Examination

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

11-1 QUALIFICATIONS

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

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

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

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

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

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

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

11-2 COMPUTATION OF TIME

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

11-3 DIME PHYSICIAN COMPLIANCE

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

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

(B) Complete a summary disclosure form;

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

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

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

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

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

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

(1) The claimant during the DIME;

(2) The requesting party to set the appointment;

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

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

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

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

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

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

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

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

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

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

11-4 DIME PROCESS

(A) Application and scheduling:

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Medical Records:

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

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

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

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

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

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

(7) Submission of supplemental records requires a prior order by an ALJ finding good cause. Supplemental records shall be prepared pursuant to this section and must be served by any party concurrently to the DIME physician and all other parties no later than seven (7) days prior to the DIME examination.

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

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

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

11-5 PAYMENTS/FEES

(A) The DIME fee will be determined based upon the length of time elapsed between the date of injury and the filing of the notice and proposal as well as body regions identified on the DIME application in accordance with the following schedule:

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

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

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

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

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

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

(1) Rescheduling fees:

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

(2) Termination fees:

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

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

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

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

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

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

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

(F) A party who seeks the presence of a DIME physician as a witness at a proceeding for any purpose, by subpoena or otherwise, shall pay the physician pursuant to Rule 18.

11-6 COMMUNICATION WITH A DIME PHYSICIAN

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

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

11-7 DIME FOLLOW-UP

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) The parties may submit additional medical records prior to the follow-up appointment in accordance with section 11-4(B).

11-8 DIMES FOLLOWING REOPENING

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

11-9 REMOVAL OF A PHYSICIAN FROM THE SELECTION PROCESS

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

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

(1) A misrepresentation on the application for appointment;

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

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

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

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

11-10 IMMUNITY

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

11-11 DISPUTES

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

11-12 INDIGENT CLAIMANT

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

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

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

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

(E) The determination regarding indigence shall be based on the claimant's financial status on the date the application is filed and any extraordinary circumstances. In ruling on the application, the ALJ shall apply the standards set forth in Rule 18. Extraordinary circumstances exist where the claimant would be deprived of the ability to provide for basic necessities that cannot be deferred, such as food, shelter, clothing, utilities and out of pocket medical costs.

(F) The costs of the DIME advanced on behalf of the indigent claimant shall be taken as an offset against permanent indemnity benefits following either a final order or approved settlement.

Rule 12 Permanent Impairment Rating Guidelines

12-1 STATEMENT OF PURPOSE

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

12-2 PROVIDER RESPONSIBILITIES

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

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

12-3 APPORTIONMENT

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

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

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

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

12-4 PERMANENT PHYSICAL IMPAIRMENT RATINGS

Any physician determining permanent physical impairment shall:

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

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

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

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

12-5 PERMANENT MENTAL AND BEHAVIORAL DISORDER IMPAIRMENT RATINGS

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

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

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

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

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

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

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

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

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

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

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

12-6 PERMANENT IMPAIRMENT RATINGS OF THE EXTREMITIES

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

(1) Forearm at the elbow;

(2) Joints at the wrist or ankle;

(3) Leg at the knee; or

(4) Toes at the metatarsal.

The AMA Guides define these as permanent impairments of the:

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

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

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

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

12-7 PERMANENT IMPAIRMENT RATINGS FOR CUMULATIVE TRAUMA

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

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

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

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

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

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

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

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

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

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation

PERMANENT WORK-RELATED MENTAL IMPAIRMENT RATING REPORT WORK SHEET

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

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

SCORING INSTRUCTIONS:

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

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

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

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

5. To obtain the final overall impairment rating:

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

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

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

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

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

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

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

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

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

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

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

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

WORKSHEET

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

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

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

II. LEVELS OF PERMANENT MENTAL IMPAIRMENT

Category

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

III. AREAS OF FUNCTION[1]

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

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

Overall Category Rating:
(average of 2 highest)
_____

2. Social Functioning

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

Overall Category Rating:
(average of 2 highest)
_____

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

3. Thinking, Concentration & Judgment

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

Overall Category Rating:
(average of 2 highest)
_____

4. Adaptation to Stress

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

Overall Category Rating:
(average of 2 highest)
_____

IV. FINAL CALCULATIONS:

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

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

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

Overall Psychiatric Permanent Impairment

Rating _____%

OR

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

IF ZERO % PSYCHIATRIC RATING

RATING_____%

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

Combined with psychiatric permanent impairment equals:

Total Whole Person Impairment (including psychiatric impairment)
_____%

Physician: _____ Date: _____
(Signature)

APPENDIX

1. Activities of Daily Living

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

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

2. Social Functioning

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

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

3. Thinking, Concentration and Judgment

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

4. Adaptation to Stress

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Rule 13 Provider Accreditation

13-1 STATEMENT OF BASIS AND PURPOSE

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

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

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

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

13-2 ACCREDITATION

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

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

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

(3) Complete the Division Level I course;

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

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

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

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

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

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

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

(4) Complete the Division Level II course;

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

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

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

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

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

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

13-3 RENEWAL OF ACCREDITATION

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

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

(C) To renew accreditation, a provider must:

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

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

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

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

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

13-4 SANCTIONS UPON ACCREDITATION

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

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

(2) Misrepresentation on the application for accreditation, or

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

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

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

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

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

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

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

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

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

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

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

14-3 TERMINATING BENEFITS FROM THE MAJOR MEDICAL INSURANCE FUND

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15-1 STATEMENT OF BASIS AND PURPOSE

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

15-2 DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15-4 SUBMISSION AND IMPLEMENTATION OF THE VOCATIONAL REHABILITATION PLAN

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15-6 REPORTING REQUIREMENT

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

15-7 QUALIFIED REHABILITATION VENDOR

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

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

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

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

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

Rule 16 Utilization Standards

16-1 STATEMENT OF PURPOSE

In an effort to comply with the legislative charge to assure the quick and efficient delivery of medical benefits at a reasonable cost, the Director (Director) of the Division of Workers' Compensation (Division) has promulgated these utilization standards, effective January 1, 2020. 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.

16-2 STANDARD TERMINOLOGY FOR RULES 16, 17, 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 physician selected by the injured worker when the injured worker has the right to select a provider;

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

(5) A 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) Certified Medical Interpreter - certified by the Certification Commission for Healthcare Interpreters or the National Board of Certification for Medical Interpreters.

(F) Children's Hospital – federally qualified, and certified by the Colorado Department of Public Health and Environment.

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

(H) Critical Access Hospital (CAH) – federally qualified, and certified by the Colorado Department of Public Health and Environment.

(I) Day – defined as a calendar day unless otherwise noted. In computing any period of time prescribed or allowed by Rules 16 or 18, the parties shall refer to Rule 1-2.

(J) Free-Standing Facility – an entity that furnishes healthcare services and is not integrated with any other entity as a main provider, a department of a provider, remote location of a hospital, satellite facility, or provider–based entity.

(K) Hospital – licensed by the Colorado Department of Public Health and Environment.

(L) Long-Term Care Facility –federally qualified, and certified by the Colorado Department of Public Health and Environment.

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

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

(O) Over-the-Counter Drugs – medications that are available for purchase by the general public without a prescription.

(P) Payer – an insurer, self-insured employer, or designated agent(s) responsible for payment of medical expenses. Use of agents, including but not limited to Preferred Provider Organizations (PPO) networks, bill review companies, Third Party Administrators (TPAs), and case management companies, shall not relieve the self-insured employer or insurer from their legal responsibilities for compliance with these Rules.

(Q) Prior Authorization – assurance that appropriate reimbursement for a specific treatment will be paid in accordance with Rule 18, its exhibits, and the documents incorporated by reference in that Rule.

(R) 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.

(S) Psychiatric Hospital – licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

(T) Rehabilitation Hospital Facility – licensed as a rehabilitation hospital by the Colorado Department of Public Health and Environment.

(U) Rural Health Clinic Facility – federally qualified, and certified by the Colorado Department of Public Health and Environment.

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

(W) Telemedicine – two-way, real time interactive communication between the injured worker, and the provider at the distant site. This electronic communication involves, at minimum, audio and video telecommunications equipment. Telemedicine enables the remote diagnoses and evaluation of injured workers in addition to the ability to detect fluctuations in their medical condition(s) at a remote site in such a way as to confirm or alter the treatment plan, including medications and/or specialized therapy.

(X) Veterans' Administration Medical Facilities – all medical facilities overseen by the United States Department of Veterans' Affairs.

16-3 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 boards:

(i) Colorado Medical Board;

(ii) Colorado Dental Board;

(iii) Colorado Podiatry Board;

(iv) Colorado Optometry Board, or

(v) Colorado Board of Chiropractic Examiners;

Only physicians licensed by the Colorado Medical Board may be included as individual physicians on the employer's or insurer's designated provider list required under § 8-43-404(5)(a)(I).

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

(i) Acupuncturist (LAc) – licensed by the Office of Acupuncture Licensure, Colorado Department of Regulatory Agencies;

(ii) Advanced Practice Nurse (APN) – licensed by the Colorado Board of Nursing; Advanced Practice Nurse Registry;

(iii) Anesthesiologist Assistant (AA) – licensed by the Colorado Medical Board, Colorado Department of Regulatory Agencies;

(iv) Athletic Trainers (ATC) –licensed by the Colorado Department of Regulatory Agencies;

(v) Audiologist (AU.D. CCC-A) – licensed by the Office of Audiology and Hearing Aid Provider Licensure, Colorado Department of Regulatory Agencies;

(vi) Certified Registered Nurse Anesthetist (CRNA) – licensed by the Colorado Board of Nursing;

(vii) Clinical Social Worker (LCSW) – licensed by the Board of Social Work Examiners, Colorado Department of Regulatory Agencies;

(viii) Durable Medical Equipment, Prosthetic, Orthotics and Supplies (DMEPOS) Supplier – licensed by the Colorado Secretary of State;

(ix) Marriage and Family Therapist (LMFT) – licensed by the Board of Marriage and Family Therapist Examiners, Colorado Department of Regulatory Agencies;

(x) Massage Therapist (MT) – licensed as a massage therapist by the Office of Massage Therapy Licensure, Colorado Department of Regulatory Agencies.

(xi) Nurse Practitioner (NP) – licensed as an APN and authorized by the Colorado Board of Nursing;

(xii) Occupational Therapist (OTR) – licensed by the Office of Occupational Therapy, Colorado Department of Regulatory Agencies;

(xiii) Occupational Therapist Assistant (OTA) – licensed by the Office of Occupational Therapy, Colorado Department of Regulatory Agencies;

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

(xv) Pharmacist – licensed by the Board of Pharmacy, Colorado Department of Regulatory Agencies;

(xvi) Physical Therapist (PT) – licensed by the Physical Therapy Board, Colorado Department of Regulatory Agencies;

(xvii) Physical Therapist Assistant (PTA) –certified by the Physical Therapy Board, Colorado Department of Regulatory Agencies;

(xviii) Physician Assistant (PA) – licensed by the Colorado Medical Board;

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

(xx) Professional Counselor (LPC) – licensed by the Board of Professional Counselor Examiners, Colorado Department of Regulatory Agencies;

(xxi) Psychologist (PsyD, PhD, EdD) – licensed by the Board of Psychologist Examiners, Colorado Department of Regulatory Agencies;

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

(xxiii) Respiratory Therapist (RTL) – certified by the National Board of Respiratory Care and licensed by the Office of Respiratory Therapy Licensure, Colorado Department of Regulatory Agencies;

(xxiv) Speech Language Pathologist (CCC-SLP) – certified by the Office of Speech-Language Pathology Certification, Colorado Department of Regulatory Agencies; and

(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 section 16-3(A)(1)(a) or (b) must comply with section 16-6, Prior Authorization when providing all services.

(4) Referrals:

(a) A payer or employer shall not redirect or alter the scope of a 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 a physician provider managing the claim (or NP/PA working under that physician provider). A physician making the referral to any listed or unlisted non-physician provider shall, upon request of any party, answer any questions and clarify the scope of the referral, prescription, or the reasonableness or necessity of the care.

(5) Use of PAs and NPs in Colorado Workers' Compensation Claims:

(a) All Colorado workers' compensation claims (medical only or lost time claims) shall have an "authorized treating physician" responsible for all services rendered to an injured worker by any PA or NP.

(b) For services performed by an NP or a PA, the authorized treating physician must counter-sign patient records related to the injured worker's inability to work resulting from the claimed work injury or disease, and the injured worker's ability to return to regular or modified employment, as required by §§ 8-42-105(2)(b) and (3). The authorized treating physician also must counter-sign Form WC 164. The signature of the physician provider shall serve as a certification that all requirements of this rule have been met.

(c) The authorized treating physician must evaluate the injured worker within the first three visits to the physician's office.

(B) Out-of-State Provider

(1) Relocated Injured Worker

(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:

(i) Through referral by the injured worker's authorized treating physician; or

(ii) In accordance with § 8-43-404(5)(a).

(2) Referred Injured Worker

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 section 16-6. 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.

16-4 REQUIRED USE OF THE MEDICAL TREATMENT GUIDELINES

When an injury or occupational disease falls within the purview of Rule 17, Medical Treatment Guidelines and the 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 or rely on its' own internal guidelines or other standards for medical determination. Initial recommendations for a treatment or modality should not exceed the time to produce functional effect parameters in the applicable Medical Treatment Guidelines. When treatment exceeds or is outside of the Medical Treatment Guidelines, prior authorization is required. Requesters and reviewers should consider how their decision will affect the overall treatment plan for the individual patient. In all instances of denial, appropriate processes to deny are required.

16-5 NOTIFICATION

(A) The Notification process is for treatment consistent with the Medical Treatment Guidelines that has an established value under the Medical Fee Schedule. Providers may, but are not required to, utilize the Notification process to ensure payment for medical treatment that falls within the purview of the Medical Treatment Guidelines. Therefore, lack of response from the payer within the time requirement set forth in section 16-5(D) shall deem the proposed treatment/service authorized for payment.

(B) Notification may be made by phone, during regular business hours.

(1) Providers can accept verbal confirmation; or

(2) Providers may request written confirmation of an approval, which the payer should provide upon request.

(C) Notification may be submitted using the "Authorized Treating Provider's Notification to Treat" (Form WC 195). The completed form shall include:

(1) Provider's certification that the proposed treatment/service is medically necessary and consistent with the Medical Treatment Guidelines.

(2) Documentation of the specific Medical Treatment Guideline(s) applicable to the proposed treatment/service.

(3) Provider's email address or fax number to which the payer can respond.

(D) Payers shall respond to a Notification submission within five (5) business days from receipt of the request with an approval or a denial of the proposed treatment.

(1) The payer may limit its approval to the number of treatments or treatment duration specified in the relevant Medical Treatment Guideline(s), without a medical review. If subsequent medical records document functional progress, additional treatment should be approved.

(2) If payer proposes to discontinue treatment before the maximum number of treatments/treatment duration has been reached due to lack of functional progress, payer shall support that decision with a medical review compliant with section 16-7(B).

(E) Payers may deny the proposed treatment only for the following reasons:

(1) For claims which have been reported to the Division, no admission of liability or final order finding the injury compensable has been issued:

(2) Proposed treatment is not related to the admitted injury;

(3) Provider submitting Notification is not an ATP, or is proposing for treatment to be performed by a provider who is not eligible to be an ATP;

(4) Injured worker is not entitled to proposed treatment pursuant to statute or settlement;

(5) Medical records contain conflicting opinions among the ATPs regarding proposed treatment;

(6) Proposed treatment falls outside the Medical Treatment Guidelines.

(F) If the payer denies Notification under sections 16-5(E)(2), (5) or (6) above, the payer shall notify the provider, allow the submission of relevant supporting medical documentation as defined in section 16-6(E), and review the submission as a prior authorization request, allowing an additional seven (7) business days for review.

(G) Appeals for denied Notification by a provider shall be made in accordance with the prior authorization appeals process outlined in 16-7(C).

(H) Any provider or payer who incorrectly applies the Medical Treatment Guidelines in the Notification process may be subject to penalties under the Workers' Compensation Act.

16-6 PRIOR AUTHORIZATION

(A) Granting of prior authorization is a guarantee of payment in accordance with Rule 18, RBRVS, and CPT® for the services/procedures requested by the provider pursuant to section 16-6(E). Prior authorization may be requested using the "Authorized Treating Provider's Request for Prior Authorization" (Form WC 188) or, in the alternative, shall be clearly labeled as a prior authorization request.

(B) Prior authorization for payment shall only 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 Medical Fee Schedule as referenced in section 16-8(C).

(C) Prior authorization for a prescribed service or procedure may be granted immediately and without a medical review. However, the payer shall respond to all prior authorization requests in writing within seven (7) business days from receipt of the provider's completed request, as defined in section 16-6(E). The duty to respond to a provider's request applies regardless of who transmitted the request.

D) The payer, unless it has 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 reasonableness and the medical necessity of the services requested, and shall 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. The following documentation is required:

(1) An adequate definition or description of the nature, extent, and necessity for the procedure;

(2) Identification of the appropriate Medical Treatment Guideline, if applicable; and

(3) Final diagnosis.

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

(G) If, after the service was provided, the payer agrees the service was reasonable and necessary, lack of prior authorization does not warrant denial of payment. However, the provider is still required to provide, with the bill, the documentation required by section 16-6(E) for any unlisted service or procedure for payment.

16-7 DENIAL OF A REQUEST FOR PRIOR AUTHORIZATION

(A) If an ATP requests prior authorization and indicates in writing, including reasoning and relevant documentation, that he or she believes the requested treatment is related to the admitted workers' compensation claim, the insurer cannot deny solely for relatedness without a medical opinion as required by section 16-7(B). The medical review, IME report, or report from an ATP that addresses the relatedness of the requested treatment to the admitted claim may precede the prior authorization request unless the requesting physician presents new reasoning or relevant documentation that supports his or her opinion that the treatment is now related.

(B) The payer may deny a request for prior authorization for medical or non-medical reasons. Examples of non-medical reasons are listed in section 16-11(B)(1). If the payer is denying 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 section 16-6(E) reviewed by a "physician provider" as defined in section 16-3(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 physician providers performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review prior authorization requests for medications without having received Level I or Level II accreditation.

(2) After reviewing all the submitted documentation and other documentation referenced in the prior authorization request and available to the payer, the reviewing provider may call the requesting provider to expedite communication and processing of prior authorization requests. However, the written denial or approval still needs to be completed within the seven (7) business days specified under this section.

(3) Furnish the provider and the parties with a written denial that sets forth the following information:

(a) An explanation of the specific medical reasons for the denial, 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 Medical Treatment Guidelines, when applicable;

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

(d) Documentation of response to the provider and parties.

(C) Prior Authorization Appeals

(1) The requesting party or provider shall have seven (7) business days from the date of the written denial to provide a written response to the payer. 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 response to issue a final decision and provide documentation of that decision 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 ATP, shall be deemed good cause for an expedited hearing.

(E) Failure of the payer to timely comply in full with section 16-7(A), (B), or (C) shall be deemed authorization for payment of the requested treatment unless the payer has scheduled an independent medical examination (IME) and notified the requesting provider of the IME within the time prescribed for responding set forth in section 16-7(B).

(1) The IME must occur within 30 days, or upon first available appointment, of the prior authorization request, not to exceed 60 days absent an order extending the deadline.

(2) The IME physician must serve all parties concurrently with his or her report within 20 days of the IME.

(3) The insurer shall respond to the prior authorization request within five business days of the receipt of the IME report.

(4) If the injured worker does not attend or reschedules the IME, the payer may deny the prior authorization request pending completion of the IME.

(5) The IME shall comply with Rule 8 as applicable.

(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.

16-8 REQUIRED USE OF THE FEE SCHEDULE

(A) All providers and payers shall use the Medical Fee Schedule to determine the maximum allowable payments for any medical treatments or services within the purview of the Workers' Compensation Act of Colorado and the Colorado Workers' Compensation Rules of Procedure, unless one of the following exceptions applies:

(1) If billed charges are less than the fee schedule, the payment shall not exceed the billed charges.

(2) The payer and an out-of-state provider may negotiate reimbursement in excess of the fee schedule when required to obtain reasonable and necessary care for an injured worker.

(3) Pursuant to § 8-67-112(3), the Uninsured Employer Board may negotiate rates of reimbursement for medical providers.

(B) The fee schedule does not limit the billing charges.

(C) Payment for billed services not identified or identified but without established value in the Medical Fee Schedule shall require prior authorization from the payer pursuant to section 16-6, except when the billed non-established valued service or procedure is an emergency or a payment mechanism under Rule 18 is identifiable, but not explicit. Examples of these exception(s) include ambulance bills or supply bills that are covered under Rule 18 with an identified payment mechanism. Similar established code values from the Medical Fee Schedule, recommended by the requesting physician, shall govern the maximum fee schedule payment.

16-9 REQUIRED BILLING FORMS, CODES, AND PROCEDURES

(A) Medical providers shall use only the billing forms listed below or their electronic reproductions. Any reproduction shall be an exact duplication of the form(s) in content and appearance. If the payer agrees, providers may place identifying information in the margin of the form. Payment for any services not billed on the forms identified in this Rule may be denied. However, the payer shall comply with the applicable provisions set forth in section 16-11.

(1) CMS (Centers for Medicare & Medicaid Services) -1500 shall be used by all providers billing for professional services, durable medical equipment (DME) and ambulance services, with the exception of those providers billing for dental services or procedures. Health care providers shall provide their name and credentials in the appropriate box of the CMS-1500. Non-hospital based ASCs may bill on the CMS-1500, however an SG modifier must be appended to the technical component of services to indicate a facility charge and to qualify for reimbursement as a facility claim.

(2) UB-04 - shall be used by all hospitals, hospital-based ambulance/air services, Children's Hospitals, CAHs, Veterans' Administration Medical Facilities, home health and facilities meeting the definitions found in section 16-2, when billing for hospital services or any facility fees billed by any other provider, such as hospital-based ASCs.

(a) Some outpatient hospital therapy services (Physical, Occupational, or Speech) may also be billed on a UB-04. For these services, the UB-04 must have Form Locator Type 013x, 074x, 075x, or 085x, and one of the following revenue code(s):

- Revenue Code 042X Physical Therapy
- Revenue Code 043X Occupational Therapy
- Revenue Code 044X Speech/Language Therapy

(b) CAHs designated by Medicare or Exhibit # 3 to Rule 18 may use a UB-04 to bill professional services if the professional has reassigned his or her billing rights to the CAH using Medicare's Method II. The CAH shall list bill type 851-854, as well as one of the following revenue code(s) and Health Care Common Procedure Coding System (HCPCS) codes in the HCPCS Rates field number 44:

- 0960 - Professional Fee General
- 0961 - Psychiatric
- 0962 - Ophthalmology
- 0963 - Anesthesiologist (MD)
- 0964 - Anesthetist (CRNA)
- 0971 - Professional Fee For Laboratory
- 0972 - Professional Fee For Radiology Diagnostic
- 0973 – Professional Fee - Radiology - Therapeutic
- 0974 - Professional Fee - Radiology - Nuclear
- 0975 - Professional Fee - Operating Room
- 0981 - Emergency Room Physicians
- 0982 - Outpatient Services
- 0983 - Clinic
- 0985 - EKG Professional
- 0986 - EEG Professional
- 0987 - Hospital Visit Professional (MD/DO)
- 0988 - Consultation (Professional (MD/DO)

All professional services billed by a CAH are subject to the same coding and payment rules as professional services billed independently. The following modifiers shall be appended to HCPCS codes to identify the type of provider rendering the professional service:

GF Services rendered in a CAH by a NP, clinical nurse specialist, certified registered nurse, or PA
SB Services rendered in a CAH by a nurse midwife
AH Services rendered in a CAH by a clinical psychologist
AE Services rendered in a CAH by a nutrition professional/registered dietitian
AQ Physician services in a physician-scarcity area

(c) No provider except those listed above shall bill for the professional fees using a UB-04.

(3) American Dental Association's Dental Claim Form, Version 2019 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.

Dispensing pharmacies and pharmacy benefit managers shall use NCPDP Workers' Compensation/Property and Casualty (P&C) universal claim form, version 1.1, for prescription drugs billed on paper. Physicians may use the CMS-1500 billing form as described in section 16-9(A)(1).

(5) Bills for services incident to medical services, such as language interpreting or injured worker mileage reimbursement, may be submitted by invoice or other agreed-upon form.

(B) International Classification of Diseases (ICD) Codes

All provider bills shall list the ICD-10 Clinical Modification (CM) diagnosis code(s) that are current, accurate, specific to each patient encounter, and preferably include the Chapter 20 External Causes of Morbidity code(s). If ICD-10-CM requires a seventh character, the provider must apply it in accordance with the ICD-10-CM Chapter Guidelines provided by the Centers for Medicare and Medicaid Services (CMS). The ICD-10-CM diagnosis codes shall not be used as a sole factor to establish work-relatedness of an injury or treatment.

(C) Providers must accurately report their services using applicable billing codes, modifiers, instructions, and parenthetical notes listed in the Medical Fee Schedule; the National Relative Value File, as published by Medicare in the April 2019 Resource Based Relative Value Scale (RBRVS); and the American Medical Association's Current Procedural Terminology (CPT®) 2019 edition. The provider may be subject to penalties 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.

(D) National provider identification (NPI) numbers are required for workers' compensation bills; providers who cannot obtain NPI numbers are exempt from this requirement. When billing on a CMS-1500, the NPI shall be that of the rendering provider and shall include the correct place of service codes at the line level.

(E) Timely Filing

Providers shall submit their bills for services rendered within 120 days of the date of service or the bill may be denied unless extenuating circumstances exist. For claims submitted through electronic data interchange (EDI), providers may prove timely filing by showing a payer acknowledgement (claim accepted). Rejected claims or clearinghouse acknowledgment reports are not proof of timely filing. For paper claims, providers may prove timely filing with a signed certificate of mailing listing the original date mailed and the payer's address; a fax acknowledgment report; or certified mail receipt showing the date the payer received the claim. All timely filing issues will be considered final 10 months from date of service unless extenuating circumstances exist.

Injured workers shall submit requests for mileage reimbursement within 120 days of the date of service or reimbursement may be denied unless good cause exists.

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.

16-10 REQUIRED MEDICAL RECORD DOCUMENTATION

(A) The treating provider shall maintain medical records for each injured worker when billing for the provided services. The rendering provider shall sign the medical records. Electronic signatures are accepted.

(B) All medical records shall legibly document the services billed. The documentation shall itemize each contact with the injured worker. The documentation also shall detail at least the following information per contact or, if contact occurs more than once per week, detail at least 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) Pain diagrams, where applicable;

(8) 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

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

(C) All services provided to patients are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided are not made timely. In this event, the documentation will need to be amended, corrected, or entered after rendering the service. Amendments, corrections, and delayed entries must comply with Medicare's widely accepted recordkeeping principles as outlined in the April 2018 Medicare Program Integrity Manual Chapter 3, section 3.3.2.5. (This section does not apply to patients' requests to amend records as permitted by the Health Insurance Portability and Accountability Act (HIPAA)).

(D) Authorized treating physicians must sign (or counter-sign) and submit to the payer, with their initial and final visit billings, a completed "Physician's Report of Workers' Compensation Injury" (Form WC 164) specifying:

(1) The report type as "initial" when the injured worker has his or her initial visit with the authorized treating physician managing the total workers' compensation claim (generally the designated or selected physician). If applicable, the emergency department (ED) or urgent care authorized treating physician for this workers' compensation injury also may create a Form WC 164 initial report. Unless requested or preauthorized by the payer to a specific workers' compensation claim, no other authorized physician should complete and bill for the initial Form WC 164. See Rule 18 for required fields.

(2) The report type as "closing" when the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim determines the injured worker has reached maximum medical improvement (MMI) for all covered injuries or diseases, with or without permanent impairment. See Rule 18 for required fields. If the injured worker has sustained a permanent impairment, item 10 also must be completed and the following information shall be attached to the bill at the time of MMI:

(a) All necessary permanent impairment rating reports, including a narrative report and appropriate worksheets, when the authorized treating physician managing the total workers' compensation claim of the patient is Level II Accredited; or

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

(3) At no charge, the physician shall supply the injured worker with one legible copy of the completed Form WC 164 at the time the form is completed.

(4) The provider shall submit to the payer the completed Form WC 164 no later than 14 days from the date of service.

E) Providers other than hospitals shall provide the payer with all supporting documentation at the time of billing unless the parties have made other agreements. This shall include copies of the examination, surgical, and/or treatment records. Hospitals shall provide documentation to the payer upon request. Payers shall specify what portion of a hospital record is being requested (for example, only the ED chart notes, in-patient physician orders and chart notes, x-rays, pathology reports, etc.).

(F) In accordance with section 16-11(B), the payer may deny payment for billed services until the provider submits the relevant required documentation.

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 (EOB). If 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, the payer's written notice shall include:

(a) Name of the injured worker;

(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 submit corrected bill or appeal within 60 days;

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

(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; and

(k) Name and address of the third party administrator (TPA) and name and address of the bill reviewer if separate company when known; and

(l) If applicable, a statement that the payment is being held in abeyance because a hearing is pending on a relevant issue.

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

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

(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 Medical 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, presumed 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 to be used during an audit.

(8) Payers shall reimburse injured workers for mileage expenses as required by statute or provide written or electronic notice of the reasons for denying reimbursement within 30 days of receipt.

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

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

(2) If an ATP bills for medical services and indicates in writing, including reasoning and relevant documentation that he or she believes the medical services are related to the admitted WC claim, the payer cannot deny payment solely for relatedness without a medical opinion as required by section 16-11(C). The medical review, IME report, or report from an ATP that addresses the relatedness of the requested treatment to the admitted claim may precede the received billed service unless the requesting physician presents new reasoning or relevant documentation that supports his or her opinion that the treatment is now related.

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

(a) Date(s) of service(s) being denied, if submitted on the bill;

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

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

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

Any notice that fails to include the required information set forth in this section is defective. Such defective notice shall not satisfy the 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 code is accurate. If the payer disagrees with the level of care billed, the payer may deny the claim or contact the provider to explain why the billed code does not meet the level of care criteria.

(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 the 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 disagrees, then the payer shall proceed according to section 16-11(B) or (C), as appropriate.

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

(6) When no established fee is given in the Medical Fee Schedule and the payer agrees the service or procedure is reasonable and necessary, the payer shall list on the EOB one of the following payment options:

(a) A reasonable value based upon the similar established code value recommended by the requesting provider, or

(b) The provider's requested payment based on an established similar code value.

If the payer disagrees with the provider's recommended code value, the denial shall include an explanation of why the requested fee is not reasonable, the code(s) used by the payer, and how the payer calculated/derived its maximum fee recommendation. If the payer is denying the medical necessity of any non-valued procedure after prior authorization was requested, the payer shall follow section 16-11(C).

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

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

(1) Have the bill and all supporting medical documentation reviewed by a "physician provider" as defined in section 16-3(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 physician providers performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review billed services for medications without having received Level I or Level II accreditation. After reviewing the supporting medical documentation, the reviewing provider may call the billing provider to expedite communication and timely processing of the medical bill.

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

(a) Date(s) of service(s) being denied, if submitted on the bill;

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

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

(d) 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 Medical Treatment Guidelines, when applicable; and

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

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

(4) If the payer is denying the medical necessity of any non-valued procedure provided without prior authorization, the payer shall follow the procedures given in sections 16-11(C)(1) and (2).

(D) Process for Appealing Billed Service Denials

(1) The billing party shall have 60 days from the date of the EOB to respond to the payer's written notice under section 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) denied;

(d) Clear and persuasive supporting documentation or reasons for 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 section 16-11(D)(1), the payer shall:

(a) When denying for medical reasons, have the bill and all supporting medical documentation and reasoning reviewed by a "physician provider" as defined in section 16-3(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 physician providers performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review billed services for medications without having received Level I or Level II accreditation. After reviewing the documentation and response, the reviewing provider may call the billing provider to expedite communication and timely processing of the medical bill.

(b) When denying for non-medical reasons, have the bill and all supporting documentation and reasoning reviewed by a person who has knowledge of the bill. After reviewing the provider's documentation and response, the reviewer may call the provider to expedite communication and timely processing of the medical bill.

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

(a) Date(s) of service(s) being denied, if submitted by the provider;

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

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

(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 denial is for a medical reason; and

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

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

(6) In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts. The parties shall do so within 12 months of the date the original bill should have been processed in compliance with section 16-11, unless extenuating circumstances exist.

(E) Retroactive review of Medical Bills

(1) All medical bills paid by a payer shall be considered final at 12 months after the date of the original EOB unless the provider is notified that:

(a) A hearing is requested within the 12 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 provider" as defined in section 16-3(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 physician providers performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review billed services for medications without having received Level I or Level II accreditation. The payer shall send the billing party written notice that shall include all notice requirements set forth in section 16-11(A)(1) and also shall include:

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

(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 notice requirements set forth in section 16-11(A)(1) and shall also include:

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

(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 may follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.

(F) 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 under the Workers' Compensation Act, the payer shall reimburse the injured worker for the amounts actually paid for authorized services within 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.

(G) 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 section 16-11.

(H) Onsite Review of Hospital or Other Medical Charges

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

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

Within 30 days of receipt of the bill, 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:

(a) Name of the injured worker;

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

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

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

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

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

(b) 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;

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

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

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

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

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

(b) Negotiate the starting date for the review;

(c) 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;

(d) 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 ten (10) business day response period for the hospital or other medical facility, and the delivery of an itemized list of discrepancies at an exit conference upon the completion of the review; and

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

16-12 DISPUTE RESOLUTION PROCESS

When seeking dispute resolution from the Division's Medical Dispute Resolution Unit, the requesting party must complete the Division's "Medical Dispute Resolution Intake Form" (Form WC 181) found on the Division's web page. The items listed on the bottom of the form must be provided at the time of submission. If necessary items are missing or if more information is required, the Division will forward a request for additional information and initiation of the process may be delayed.

When the request is properly made and the supporting documentation submitted, the Division will issue a confirmation of receipt. If, after reviewing the materials, the Division believes the dispute criteria have not been met, the Division will issue an explanation of those reasons. If the Division determines there is cause for facilitating the disputed items, the other party will be sent a request for a written response due in ten (10) business days.

The Division will facilitate the dispute by reviewing the parties' compliance with Rules 11, 16, 17, and 18 within 30 days of receipt of the complete supporting documentation; or as soon thereafter as possible. In addition, the payer shall pay interest at the rate of eight percent per annum in accordance with § 8-43-410(2), upon all sums not paid timely and in accordance with the Division Rules. The interest shall be paid at the same time as any delinquent amount(s).

Upon review of all submitted documentation, disputes resulting from violation of Rules 11, 16, 17 and 18, as determined by the Director, may result in a Director's Order that cites the specific violation.

Evidence of compliance with the order shall be provided to the Director. If the party does not agree with the findings, it shall state with particularity and in writing its reasons for all disagreements by providing a response with all relevant legal authority, and/or other relevant proof upon which it relies in support of its position(s) concerning disagreements with the order.

Failure to respond or cure violations may result in penalties in accordance with § 8-43-304. Daily fines up to $1,000/day for each such offence will be assessed until the party complies with the Director's Order.

Resolution of disputes not pertaining to Rule violations will be facilitated by the Division to the extent possible. In the event both parties cannot reach an agreement, the parties will be provided additional information on pursuing resolution and adjudication procedures available through the Office of Administrative Courts. Use of the dispute resolution process does not extend the 12 month application period for hearing..

Rule 17 Medical Treatment Guidelines

17-1. STATEMENT OF PURPOSE

The Director adopts the medical treatment guidelines pursuant to § 8-42-101(3.5)(a)(ii), C.R.S.. The purpose of these guidelines is to comply with § 8-40-102(1), C.R.S., and assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation.

17-2. USE OF THE MEDICAL TREATMENT GUIDELINES

(A) All health care providers shall use the medical treatment guidelines promulgated by the Director, as required by § 8-42-101(3)(B), C.R.S..

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

17-3. PROVIDER'S RESPONSIBILITIES

(A) The health care provider shall prepare a diagnosis-based treatment plan that includes specific treatment goals with expected time frames for completion in all cases where treatment falling within the purview of the medical treatment guidelines continues beyond 6 weeks.

(B) Within 14 days of request by any party, the provider shall supply a copy of the treatment plan both to the patient and to the payer. Should the patient otherwise require care that deviates from the medical treatment guidelines, the provider shall supply the patient and the payer with a written explanation of the medical necessity for such care.

17-4. PROCEDURE FOR QUESTIONING CARE

(A) The medical treatment guidelines set forth reasonable medical care for high cost or high frequency categories of occupational injury or disease. However, the Division recognizes reasonable medical care may include deviations from the guidelines in individual cases.

The provider must request prior authorization if the proposed treatment falls outside the medical treatment guidelines, if the guidelines require prior authorization for a proposed treatment, or if rules 16-9 (b)(1)-(4) apply, the provider *may* request prior authorization to receive a guarantee of payment.

(B) Rule 16-10 governs the contest of a request for prior authorization.

(C) If the payer questions whether treatment that has been provided is consistent with the medical treatment guidelines, the procedure for contesting payment is covered in Rule 16-11 (C).

17-5. EXHIBITS TO RULE 17

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

(B) Exhibit 2 – Traumatic Brain Injury 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 Conditions 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

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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 All Versions list on the rule's current version page. To view versions effective on or after 01/01/2011, select the desired part of the rule, for example 7 CCR 1101-3 Rules 1-17, or 7 CCR 1101-3 Rule 18: Exhibit 1.

History

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