

COLORADO DEPARTMENT OF LABOR & EMPLOYMENT

Division of Workers' Compensation

ADJUSTER'S GUIDE



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**THE INFORMATION IN THIS
BOOKLET IS INTENDED TO
BE GENERAL INFORMATION
ON THE COLORADO
WORKERS' COMPENSATION
SYSTEM AND IS NOT
INTENDED TO BE A
SUBSTITUTE FOR LEGAL
ADVICE**

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I. INTRODUCTION

It is the intent of the general assembly that the “Workers’ Compensation Act of Colorado” be interpreted so as to 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, recognizing that the workers’ compensation system in Colorado is based on a mutual renunciation of common law rights and defenses by employers and employees alike.

Colorado Workers’ Compensation Act, C.R.S. § 8-40-102

The Division of Workers’ Compensation, a division of the Colorado Department of Labor and Employment, administers the workers’ compensation system in Colorado.

This Guide is produced as an informational tool for claims adjusting in Colorado. Generally, the information pertains to claims with dates of injury on or after July 1, 1991, when significant reform legislation was signed into law. The date of injury will affect benefits and procedural requirements related to the claim.

Although this Guide primarily addresses paper forms, the information can be applied to electronic transmissions. The Division encourages use of Electronic Data Interchange (EDI) using the International Association of Industrial Accident Boards and Commissions (IAIABC) format. We currently accept electronic transmissions of First Reports of Injury, Notices of Contest and Final Payment Notices and anticipate accepting electronic transmission of position statements.

The Colorado Division of Workers’ Compensation maintains a website at <http://coworkforce.com/DWC/> where Division information, publications, rules, statutes, notices, and commonly used forms may be accessed. Forms are available in PDF, Word and fillable formats and can be downloaded or printed. Please refer to the Division website for the most current version.

In the following pages, reference is made to the Colorado Revised Statutes (C.R.S.) and to the Rules of Procedure (Rule). The Workers' Compensation Act can be accessed through our website or a copy obtained from our Customer Service Unit. The Rules of Procedure are available on the Division website or can be purchased from **LexisNexis Matthew Bender & Co., Inc.**, 1275 Broadway, Albany, NY 12204 Phone: 1-800-223-1940 or **customer.support@lexisnexis.com** respectively.

We at the Division of Workers' Compensation hope this Guide is useful in adjusting Colorado workers' compensation claims. If this Guide does not answer a specific question, please call us. We will provide training upon request that can be tailored to meet the specific needs of an organization. Please call 303.318.8700 to schedule training.

II. USE OF DIVISION FORMS

It is imperative that claims handlers use current Division Forms. The Division website at <http://coworkforce.com/DWC/> contains the most current version of commonly used forms. All forms filed with the Division must meet the following minimum requirements or cannot be processed:

- Typed or printed legibly in blue or black ink
- All applicable fields completed
- The current form submitted

See Rule 5-1.

Block Numbers and TPA Codes

Insurance carriers licensed with the Colorado Division of Insurance to provide workers' compensation coverage and Self-Insured Employers are assigned three-digit block numbers by the Division of Workers' Compensation. This number must be on all filings made with the Division to insure that the correct insurer is established on individual claims and that mail is directed to the proper adjusting location. If the correct number is not used or is omitted, the claim may not be properly established with the Division and the employer on the claim may be identified as uninsured.

All third-party administrators (TPA) are assigned two-letter adjusting codes. This code must be on all filings made with the Division by a TPA. If a carrier adjusts claims at different locations, an adjusting code should be assigned to each location so mail is directed to the correct office.

Workers' Compensation Numbers

The Division assigns a workers' compensation number (WC#) upon receipt of an initiating document, an Employer's First Report of Injury or a Worker's Claim for Compensation. The number is forwarded to the claims handler by fax if filed by

paper, or electronically if filed by EDI. All documents filed with the Division after the initial filing must include the WC#. Documents cannot be processed without the WC#.

Order of Documents

When a carrier files the Employer's First Report of Injury and position statement simultaneously, the documents must be filed in the following order:

1. First Report Transmittal
2. Employer's First Report of Injury
3. Position Statement (Admission of Liability or Notice of Contest)
4. Supporting documentation

III. ESTABLISHING A CLAIM WITH THE DIVISION

An Employer's First Report of Injury form (First Report) must be filed with the Division within 10 days of notice or knowledge that a work-related accident results in any of the following:

- Lost time in excess of three shifts or calendar days
- Permanent impairment, or
- Contraction of an occupational disease that has been listed by the Director by rule.

A First Report must be filed with the Division *immediately* upon notice or knowledge that a work-related accident resulted in:

- Death, or
- Injury to three or more employees

See C.R.S. § 8-43-101, 8-43-103 and Rule 5-2(B)(2).

When filing is required pursuant to the above, the carrier, third-party administrator or self-insured employer electronically transmits or mails to the Division, an Employer's First Report of Injury (WC1) along with a First Report Transmittal form (WC106).

If a claim is established with the Division through a Worker's Claim for Compensation (Worker's Claim-WC15) or Dependents' Notice and Claim for Compensation (Dependents' Claim-WC18), the carrier, self-insured employer or non-insured employer identified from Division records, is provided a copy of the claim by mail.

Upon acceptance of a First Report, Worker's or Dependents' Claim, the Division assigns a Worker's Compensation number (WC#).

Whenever a First Report is filed with the Division, a position on liability must be stated within 20 days after the date the First Report is filed or should have been filed with the Division. See Rule 5-2(C).

In the case of a Worker's or Dependents' Claim, a position statement must be filed within 20 days after the Division mails a copy of the claim to the insurer. See Rule 5-2(D).

IV. FILING A POSITION STATEMENT

NOTICE OF CONTEST

A Notice of Contest (WC74) is filed to deny liability for a worker's compensation claim.

TIMELINE

A position statement must be filed within 20 days after the date the Employer's First Report of Injury is filed or should have been filed with the Division. In the case of a Worker's or Dependents' Claim, a position statement must be filed within 20 days after the Division mails a copy of the claim to the insurer.

DO NOT file a Notice of Contest on a previously admitted claim. *See* Tips.

TIPS

- ✓ Since denial of a claim may have serious economic impact on the claimant, prompt investigation of a claim is recommended when "further investigation" is checked. The carrier must clarify the nature of the investigation or what specific additional information is needed to determine liability.
- ✓ Although a claim is considered fully denied when a Notice of Contest is filed and "further investigation" is indicated, it is recommended that either a final denial or an admission of liability be filed once the final determination of liability on a claim is made.
- ✓ To limit liability on an already-admitted claim, DO NOT file a Notice of Contest. This could be construed as withdrawing from a previously-filed admission. The remarks section on a General Admission may be used to limit an insurer's admission of liability. For example, denial of liability for injury to a specific body part or medical treatment determined to be unrelated to a claim may be addressed in this manner. The provider must also be notified of any contested bills.

GENERAL ADMISSION

A General Admission of Liability (WC2) is filed to admit liability for a worker's compensation claim. The General Admission states acceptance of the claim as compensable and admits liability for reasonable and necessary medical expenses related to the injury. The General Admission may be notification of the admitted average weekly wage, the time period and rate of temporary disability benefits, medical benefits, and other benefits. *See* C.R.S. § 8-43-203(2)(b)(I).

TIMELINE

A position statement, either an admission or a Notice of Contest, must be filed within 20 days after the date the Employer's First Report of Injury is filed or should have been filed with the Division. In the case of a Worker's or Dependents' Claim, a position statement must be filed within 20 days after the Division mails a copy of the claim to the insurer. *See* page 5.

A subsequent admission is filed immediately with supporting documentation when temporary benefits are terminated or modified (if a bi-weekly check is not sent, an admission terminating benefits must be filed). *See* Rule 5-5(C).

A subsequent admission must be filed within 30 days of resumption of or increase in temporary benefits.

TIPS

✓ **Supporting documentation for termination/modification**

See Termination/Modification of Temporary Benefits in Section V, page 18, for discussion of the supporting documentation that must be filed with the General Admission when temporary benefits are terminated or modified.

✓ **Claimant is at MMI at the time of the initial filing**

If the claimant has reached maximum medical improvement (MMI) at the time of the initial position statement and permanent impairment has been addressed, a Final Admission of Liability may be filed to both establish liability and conclude the case. In this instance, a General Admission need not be filed. DO NOT file both a General and Final Admission simultaneously.

✓ **Limiting liability to a specific body part/condition**

Use the remarks section for any explanations regarding the admission of liability including limiting liability to a particular body part and to clarify benefits.

✓ **Filing subsequent admissions**

Subsequent admissions must be submitted with a Division assigned WC#. The First Report Transmittal sheet is faxed back to the carrier or TPA as soon as the WC# has been assigned. The WC# for a claim transmitted via EDI is assigned and submitted to the carrier electronically. Check internal company procedures regarding how to access the assigned WC#. All subsequent admissions must reflect all benefits previously admitted and paid.

✓ **Benefits admitted and paid may not be recovered unilaterally by admission**

An Administrative Law Judge (ALJ) may under certain specific sets of facts, such as a finding that benefits were fraudulently attained, order retroactive recovery. A carrier may Petition to Modify future benefits under Rule 6-4.

See Termination/Modification of Temporary Benefits in Section V, page 18, for discussion of the supporting documentation that must be filed with the General Admission when temporary benefits are terminated or modified.

FINAL ADMISSION

A Final Admission of Liability (WC4) is filed at the conclusion of a worker's compensation claim to summarize benefits admitted. The Final Admission notifies the claimant of what action must be taken if the claimant disagrees with the admission including applicable deadlines. If the claimant does not timely object, then the claim closes. The Final Admission also sets forth the carrier's position on liability for future benefits including permanent disability benefits, medical impairment benefits, and medical benefits after MMI. *See* C.R.S. § 8-43-203(2)(b)(II).

TIMELINE

Scheduled injuries, § 8-42-107(2)

For scheduled injuries, within 30 days after the date of mailing or delivery of a **determination of no impairment** by the authorized treating physician providing primary care, a Final Admission consistent with the physician's opinion or application for hearing must be filed. *See* Rule 5-5(H)(2).

For scheduled injuries, within 30 days after the date of mailing or delivery of a **determination of impairment** by an authorized level II accredited physician, a Final Admission consistent with the physician's opinion or application for hearing must be filed. *See* Rule 5-5(H)(2).

Non-scheduled injuries, § 8-42-107(8)

For injuries not on the schedule, within 30 days after the date of mailing or delivery of a **determination of no impairment** by the authorized treating physician providing primary care, a Final Admission consistent with the physician's opinion must be filed or application for a Division Independent Medical Examination must be filed. *See* Rule 5-5(E).

For injuries not on the schedule, within 30 days after the date of mailing or delivery of a **determination of medical impairment** by an authorized level II accredited physician, a Final Admission consistent with the physician's opinion or application for a Division Independent Medical Examination must be filed. *See Rule 5-5(E).*

TIPS

✓ **Certificate of Mailing**

The Certificate of Mailing attests to the date the Final Admission was placed in the U.S. mail and postmarked or delivered to the parties listed. The date must be completed along with the signature of the person certifying the date the Final Admission actually was placed in the U.S. mail and postmarked or delivered. Correct certification is important since the claimant has by statute 30 days from this date to object to the Final Admission. The claim will automatically close if no written objection and application for hearing or IME is made within 30 days of the date of the Final Admission.

✓ **Re-filing a Final Admission**

If an admission is re-filed, the new admission carries the same weight as the original admission. The Certificate of Mailing must be completed with the current (new) date of mailing. Information on an admission cannot be changed or additional documentation provided without re-certifying the admission and providing all attachments including the previously filed report of MMI, as this may affect the claimant's period to object and closure of the claim.

✓ **Recouping overpayments**

Temporary disability benefits paid beyond the date of MMI may be credited toward permanent impairment benefits pursuant to Rule 5-6(D). Any overpayment should be

explained in the remarks section. Any claimed overpayment may not be subject to recovery unless the issue is reserved or explicitly stated on the Final Admission.

✓ **Final Payment Notice vs. Final Admission**

Pursuant to Rule 5-11(B), a Final Payment Notice (WC25) must be filed after all compensation issues have been resolved by final admission, final order or stipulation. The final payment notice must be filed 60 days after the claim is closed. NOTE: A Final Payment Notice cannot be substituted for a Final Admission of Liability since the form does not notify the claimant of his or her right to object. The filing of a Final Payment Notice will not close a claim.

✓ **Amending a Final Admission pursuant to Rule 5-9**

Within the time limits for objecting to the Final Admission, the Director may allow a carrier to amend the admission for permanency, by notifying the parties that an error exists due to miscalculation, omission, clerical error, or misapplication of the statute. *See* Rule 5-9(A). For possible relief, notify the Division's Claims Services Section within the time limits for objecting to the admission when such an error is discovered.

FORM COMPLETION

Final Admission Checklist - in the order the items appear on the Final Admission form:

Use the following checklist to assure completeness:

- ✓ Complete the form completely and accurately.
- ✓ State the MMI date accurately (the start date of PPD benefits is the date of MMI).
- ✓ Check all benefits admitted and include totals admitted in the Benefit Summary section.
- ✓ If a stipulation has been reached and approved, do not list it in the benefit history. It should be noted on the line listed as Stipulation in the benefit summary only.

- ✓ When completing the Benefit Summary, the total medical paid should only include medical expenses, not legal fees paid or any non-medical expenses.
- ✓ Verify the PPD rating is by a Level II-accredited physician or a statement of no impairment is by the authorized treating physician providing primary care.
- ✓ Reflect the impairment rating properly in the PPD section check whether Whole Person or Scheduled Impairment and include percentage. Include age on the date of MMI if a Whole Person rating is admitted. Include Part of Body Code if a Scheduled rating is admitted.
- ✓ State position on medical benefits after MMI in easily understood language. *See* Rule 5-5(A).
- ✓ State any offsets or overpayments in the Remarks section.
- ✓ Reference the medical report upon which the Final Admission is based, including the physician's name and date of the report under "Remarks and basis of permanent disability award." *See* Rule 5-5(A). It is helpful to include the calculations for the award. *See* Calculating Indemnity Benefits in Section VI.
- ✓ If an admission is for intermittent benefits, indicate intermittent TTD or TPD under the Type of Benefits section, state beginning and ending date and attach supporting documentation.
- ✓ List all admitted permanent impairment benefits completely, including time periods, rates and totals in the Benefit History section. Only the benefits to which the carrier actually admits and intends to pay should be listed in this section.
- ✓ If benefits are limited per § 8-42-107.5, benefits should equal the applicable cap in the Benefit History and the remarks should state the cap being applied.
- ✓ Even if the PPD has been paid in a lump sum, the information on the benefit history needs to include time periods, rates, and totals. This is required as the statute of limitations runs from the last day PPD is due and payable if paid biweekly.

- ✓ If there was an overpayment, list the amount on the Amount Overpaid line and use remarks to explain how the amount will be recovered, if applicable.
- ✓ Identify the Claims Representative's name, local phone number, toll-free telephone number and address.
- ✓ Certify the actual date the document is placed in the U.S. mail or delivered.
- ✓ List the names and addresses of the parties being provided the admission.
- ✓ Provide the signature of the individual certifying mailing or delivery of the document.
- ✓ Provide all required attachments:
 - The Final Admission is a four-page document; send all four pages to **all parties**.
 - Provide support for termination or modification of temporary benefits if not filed with previous admissions.
 - Attach the MMI report and physician's worksheets.

FATAL ADMISSION

The Fatal Case-General Admission (WC151) is filed to admit liability or update a change to dependents' benefits in the case of a work-related injury resulting in death.

The Fatal Case-Final Admission (WC153) is filed when all issues have been addressed as to liability and to provide notice of appeal rights. It is filed when the deceased worker leaves no statutory dependents and payment of \$15,000.00 is made to the Subsequent Injury Fund or after all dependents' benefits have been paid out.

TIMELINE

The employer is required to give immediate notice to the Director in a case of death resulting from an injury. See C.R.S. § 8-43-103 (1).

Notice should be given by calling the Division of Workers' Compensation at 303.318.8700. The following information must be provided:

- Deceased's Last Name
- Social Security Number
- Date of Injury
- Date of Death
- Age
- Gender (M or F)
- Carrier
- Third Party Administrator (if applicable)
- Employer
- Location of accident
- Description of injury

A position statement, either an admission or a Notice of Contest, must be filed within 20 days after the date the Employer's First Report of Injury is filed or should have been filed with the Division. In the case of a Worker's or Dependents' Claim, a position statement must be filed within 20 days after the Division mails a copy of the claim to the insurer.

Establishing a claim for death benefits with the Division

The carrier must file an Employers First Report of Injury (WC1) in accordance with C.R.S. § 8-43-101(1). The box on the First Report asking: *Did injury cause death* should be marked "yes," with the corresponding date of death.

Dependents may file a Dependents' Notice and Claim for Compensation (WC18). The Division provides this form to the estate of the deceased upon notice of the fatality. The carrier may also provide this form to the estate to expedite adjustment of the claim.

Whenever a Dependents' Notice and Claim for Compensation is received on a claim where there is a preexisting injury claim and allegation of a causal connection between the injury and subsequent fatality, a separate claim must be established with the Division and assigned a distinct workers' compensation claim number. If multiple Dependents' Notice and Claims are filed for the same fatality, all will be filed under the same WC# assigned to the claim for death benefits.

Amount of death benefits

Benefits are calculated as sixty-six and two-thirds percent of the deceased employee's average weekly wage. The maximum benefit rate in effect at the time of death applies to dependent's claims. The amount of death benefits is fixed as of the date of death. If the deceased was a minor with dependents, the maximum rate applies.

Death benefits are unique in that there is a provision for payment of a minimum death benefit equal to 25% of the maximum weekly benefit in effect at the time of death. For example, if the deceased earned an AWW of \$210.00 per week at the time of death, the compensation rate for an injury claim would be \$140.00 per week. However, in the case of a dependent's claim, if the maximum compensation rate for the State of Colorado was \$593.81 at the time of death, a minimum death benefit of \$148.45 (or 25% of \$593.81) would be payable to dependents of the deceased.

The Director of the Division of Workers' Compensation or an Administrative Law Judge of the Office of Administrative Courts may apportion benefits among dependents as is determined to be "just and equitable" in accordance with C.R.S. § 8-42-121. Otherwise, benefits are apportioned on a "share and share alike" basis among persons wholly dependent. C.R.S. § 8-41-501 defines those persons who are presumed to be wholly dependent. Payment of benefits to persons partially dependent may occur only when there are no persons wholly dependent and cannot exceed a period of six years from the date of death.

No dependents: payment to the Subsequent Injury Fund

Whenever a compensable injury results in death where there are no persons wholly or partially dependent, payment must be made to the Subsequent Injury Fund (SIF) in the amount of \$15,000.00 unless the deceased is a minor with no dependents. In such cases, \$15,000.00 shall be paid to the parents of the deceased for deaths occurring on or after February 1, 2000.

The fatal final admission form must be filed for either payment to SIF or payment to the minor's parents. The form contains a check box to indicate payment owed SIF. *See* C.R.S. § 8-46-102 (1).

Offsets

For injuries occurring on or after May 29, 1991, benefits are reduced by 50% of federal survivor's benefits payable to dependents. For injuries occurring prior to May 29, 1991, the offset rate is 100%. Offsets are applied only to those dependents who receive federal survivor's benefits. *Hoffman v. Hoffman*, 872 P.2d 1367 (Colo. App.1994).

Closure of a claim for dependents' benefits

Closure on a fatal claim will generally follow the same process as closure for an injury claim. Whenever a Final Admission of Liability is filed which adheres to all the filing requirements, the Notice to Claimant section defines the requirements for timely objection to an admission. A final order in which all remaining issues are adjudicated and to which no timely appeal is received also serves to close a claim.

Claims may also be closed following a request to the Director for an Order to Show Cause why the claim should not be closed for failure to prosecute for a period of at least six months. *See* Rule 7-1(B). Questions with regard to closures of these claims may be forwarded to the Division's Customer Service Unit.

TIPS

✓ Claim established prior to death

If a claim has already been established with benefits paid for the date of injury and the claimant dies, a separate WC# must be established when filing an admission for death benefits. This is because the claimant is no longer receiving the admitted benefits and different (fatal) benefits are now being paid to dependents. If death occurs subsequent to the filing of a First Report, and a General Admission has been filed admitting for temporary disability benefits, termination of benefits may occur in accordance with Rule 6-1(A)(6).

That is, a Final Admission may be filed to terminate temporary disability benefits, whether or not death was a proximate result of the work related injury/disease. The Final Admission must be accompanied by a letter or death certificate advising of the death of the claimant with a statement by the carrier on liability for death benefits.

✓ **Claimant receiving TTD benefits at the time of death**

Compensation that a claimant would have been entitled to receive up to the date of death, is payable to dependents as may be determined by the Director or ALJ. If there are no dependents, the Director may order unpaid benefits be applied to other expenses, preferably funeral expense. *See* C.R.S. § 8-41-503. If liability is admitted for dependents' death benefits, then a separate claim is established following the above procedures.

✓ **Claimant receiving PPD benefits at the time of death**

Where death is not the proximate result of the injury and PPD benefits have been admitted, the unpaid portion of PPD benefits is due any dependents. *See* §§ 8-42-116(b) and 8-42-117(b). Where death resulted from the injury, *See* § 8-42-115 regarding distribution of benefits.

✓ **Claimant receiving PTD benefits at the time of death**

In the case of an admitted claim for PTD benefits where death is not the proximate result of the work related injury or disease, a Final Admission may be filed to terminate PTD benefits and to state a position on residual death benefits. *See* Rule 5-8(B). If the deceased leaves persons wholly dependent upon the deceased for support, death benefits consist of "the unpaid and unaccrued portion of the permanent total disability benefits which the employee would have received had the employee lived until receiving compensation at the employee's regular rate for a period of six years." *See* C.R.S. § 8-42-116 (1) (a).

If liability is admitted for dependents' death benefits, then a separate claim is established following the above procedures.

V. TERMINATION\MODIFICATION OF TEMPORARY BENEFITS

UNILATERAL TERMINATION OF TEMPORARY BENEFITS PURSUANT TO RULE 6

When temporary disability benefits are terminated or modified an admission must be filed immediately. *See* Rule 5-5(C). Supporting documentation pursuant to Rule 6 must accompany the admission for unilateral termination or reduction of temporary benefits.

Attach documents to the admission that satisfy all components of ONE of the following subsections of Rule 6 to support terminating or reducing temporary benefits:

- ✓ Signed statement by employer or employee of return to work at reduced wages and admission for TPD benefits. Rule 6-1(A)(3).
- ✓ Signed statement by employer or employee of return to work at full wages. Rule 6-1(A)(3).
- ✓ Medical release to return to regular employment. Rule 6-1(A)(2).
- ✓ Written offer of modified duty that:
 - was sent by certified mail or confirmation of the delivery of the offer by a signed certificate of service;
 - set forth duties, wages, hours; and
 - was accompanied by a statement by an authorized treating physician stating the modified employment is within the claimant's physical restrictions; and
 - a copy of the written inquiry to the physician was provided to the claimant at the time it was made to the physician; and
 - allows the claimant 3 business days to return to work in response to offer, beginning on date of receipt; and
 - includes an admission for TPD benefits, if any. Rule 6-1(A)(4).

- ✓ Letter rescheduling a missed medical appointment with the authorized treating physician that:
 - was sent by certified mail or confirmation of the delivery of the notice by a signed certificate of service;
 - stated temporary benefits would be suspended if the claimant failed to appear at a rescheduled medical appointment with the authorized treating physician (date and time of rescheduled appointment given); and documentation from the physician that the claimant failed to appear. Rule 6-1(A)(5).
- ✓ Report of MMI and impairment by an authorized treating physician provided the carrier states a position on permanency consistent with the physician's report. Rule 6-1(A)(1).
- ✓ Death certificate or letter and statement of position on liability for death benefits. Rule 6-1(A)(6).
- ✓ Documentation that substantiates any offset and calculations showing how the amount of the offset was determined pursuant to C.R.S. § 8-42-103(c). Rule 6-5. *See* Statutory Offsets; page 26.
- ✓ Certified copy of a mittimus or court document establishing confinement due to conviction. Rule 6-6.
- ✓ Copy of a document substantiating that the claimant received monetary damages from a third party claim arising from the workers' compensation injury and the amount of the award that may be offset. Rule 6-7.
- ✓ For employees of a temporary agency with dates of injury on or after July 1, 1996:
 - 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;

- 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
- a statement from the attending physician that the employment offered is within the claimant's restrictions. Rule 6-9.

PETITION TO SUSPEND, MODIFY, OR TERMINATE TEMPORARY BENEFITS

A Petition to Suspend, Modify, or Terminate Temporary Benefits (WC54) may be filed if the carrier cannot suspend, modify or terminate temporary benefits under provisions of Rules 6-1, 6-2, 6-3, 6-5, 6-6, 6-7, or 6-9 (outlined above). *See* Rule 6-4. The basis and authority for the carrier's position must be stated.

The carrier is required to send both petition and objection forms to the claimant, Division and other parties. Benefits may be suspended, modified or terminated only as of the date of the petition, when there is no timely objection by the claimant, upon discretion of the Director. If there is a dispute, the carrier must apply for hearing for determination of this issue.

If a carrier has admitted to a TTD rate and wishes to reduce the admitted TTD rate, the Petition process must be used or a hearing held and an order entered.

A carrier may not reduce an admitted TTD rate by "agreement" with a claimant not represented by an attorney since it cannot be shown the claimant had been fully informed of his or her options. Compliance with Rule 6-4 and use of Division forms provides for full notice to the claimant.

TIPS

✓ Supplemental Report of Accident

The Supplemental Report of Accident form (WC12) may be submitted to support termination or modification of temporary benefits pursuant to Rule 6.

✓ Claimant moves out of state

The fact that a claimant moves out of state is not a condition under Rule 6 for terminating temporary benefits. In such case, an authorized treating physician may refer

the claimant to a physician in the new location or the carrier and the claimant may agree on a new treating physician. Temporary benefits must continue until terminated pursuant to Rule 6.

⁶
✓ **Sick leave pay or vacation pay**

A carrier may not reduce a claimant's workers' compensation benefits because of the receipt of sick leave, annual leave, vacation pay, or other similar benefits during the time that he is temporarily disabled. *See Public Service Co. v. Johnson*, 789 P.2d 487 (Colo. App. 1990).

✓ **Claimant is terminated from employment for cause**

Temporary benefits may not be terminated unilaterally for a claimant who is allegedly terminated by the employer for cause. Termination must be sought under Rule 6-4, Suspension, Modification or Termination of Temporary Disability Benefits, by Petition, or through a fact-finding hearing.

✓ **Claimant is in jail - status of benefits**

Pursuant to C.R.S. § 8-42-113, any individual who is otherwise entitled to benefits under the Workers' Compensation Act shall neither receive nor be entitled to such benefits for any week following conviction during the time the individual is confined in a jail, prison, or any department of corrections facility.

After such individual's release from confinement, the individual shall be restored to the same position with respect to entitlement to benefits to which said individual would otherwise have been entitled at the time of such release from confinement.

Note: In case of permanent benefits, the claimant is not eligible for retroactive payments when released from confinement; permanent benefits that would be due from that date forward should be paid.

✓ **Administrative lien for child support**

If a carrier receives a Notice of Administrative Lien and Attachment, an admission should be filed with a copy of the Notice to demonstrate how and when the distribution of benefits will occur.

VI. CALCULATING INDEMNITY BENEFITS

TEMPORARY DISABILITY BENEFITS

There are two types of temporary disability benefits, temporary total and temporary partial. Both types are calculated based on the Average Weekly Wage (AWW) at the time of injury.

Temporary total disability benefits are due when a claimant is unable to work as a result of the injury and temporary partial disability benefits are due when the claimant is earning reduced wages due to the injury. For a discussion of what is included in the calculation of the AWW, see C.R.S. § 8-40-201(19). The AWW worksheet may be used to document the admitted AWW. *See Average Weekly Wage* under the *Desk Aids* section of the Division website. If the AWW on the First Report of Injury or Worker's Claim for Compensation is different from the admission, the admitted AWW must be documented. Actual wage records should be issued to determine the AWW.

TEMPORARY TOTAL DISABILITY

The claimant is considered to be totally disabled when, due to disability as the result of the work injury, no wages are earned. All benefits are calculated and paid based on a seven-day week.

The temporary total disability (TTD) benefit rate is calculated as sixty-six and two-thirds percent of the claimant's AWW up to the maximum rate established by the Director each year on July 1st. There is no minimum rate. *See* C.R.S. § 8-42-105(1).

A weekly TTD rate is calculated by multiplying the AWW by 66-2/3%.

For a discussion of AWW, *see* C.R.S. §§ 8-40-201(19) and 8-42-102.

In order to calculate a partial week of TTD, divide the weekly TTD rate by 7 and multiply the result by the number of days of TTD owed.

TEMPORARY PARTIAL DISABILITY

Temporary partial disability (TPD) benefits are due when a claimant returns to work before reaching MMI, is not released to usual duties, and is earning less than the admitted AWW. Also, TPD benefits are due if the claimant has never left work, and due to disability is unable to earn the admitted AWW.

The TPD rate should be calculated on a weekly basis by subtracting the weekly gross earnings from the admitted AWW and multiplying the result by $66\frac{2}{3}\%$.

The maximum rate is the same as the TTD rate established yearly by the Director. There is no minimum rate. Partial weeks are calculated on the basis of a seven day week. *See* C.R.S. § 8-42-106(1).

PERMANENT IMPAIRMENT BENEFITS

There are two types of permanent impairment benefits, scheduled impairment benefits and non-scheduled (whole person) impairment benefits. Pursuant to statute, each type of benefit is calculated differently. For purposes of this guide, permanent medical impairment benefits may also be referred to as PPD (permanent partial disability).

SCHEDULED IMPAIRMENT

Scheduled impairment is defined by C.R.S. § 8-42-107(2) to specific extremities and to sight and hearing. *See* exceptions at C.R.S. § 8-42-107(5), (7), and (8) (c.5).

For dates of injury prior to July 1, 1999, the statutory rate used in the calculation of impairment of scheduled injuries is \$150.00 per week. For dates of injury July 1, 1999 through June 30, 2000, the rate is \$176.00 per week. Beginning July 1, 2000 and every year thereafter, the Director of the Division of Workers' Compensation establishes the statutory rate. A listing of the Maximum Benefit Rates is available under the *Desk Aids* section of the Division web site.

To calculate medical impairment benefits for injuries on the schedule:

- determine the body part and locate the number of weeks on the schedule.
- determine the impairment rating from the physician's report of MMI and impairment.
- determine the rate to be used in the calculation based on the date of injury.

Number of weeks specified on the schedule for the body part x impairment rating x statutory rate = PPD award.

TIPS

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 C.R.S. § 8-42-107(6). *See* Rule 12-6.

NON-SCHEDULED (WHOLE PERSON) IMPAIRMENT

When an injury results in permanent medical impairment not set forth in the schedule, the benefits are calculated pursuant to C.R.S. § 8-42-107(8)(d). Permanent medical impairment benefits of non-scheduled injuries are calculated as:

Medical impairment rating x age factor x 400 weeks x TTD rate = PPD award.

To determine the age factor found at C.R.S. § 8-42-107(8)(e), use the age of the claimant on the date of MMI. (The Age Factor Chart is available under the *Desk Aids* section of the Division web site.)

The TTD rate is 66-2/3 % of the AWW on the date of injury, up to the maximum.

- **For injuries occurring on or after 7/1/99** - When a claimant sustains both scheduled and non-scheduled injuries, the losses are compensated on the schedule for scheduled injuries and the non-scheduled injuries are compensated as medical impairment benefits. *See* C.R.S. § 8-42-107(7)(b).
- **For injuries occurring prior to 7/1/99** - When a claimant sustains both scheduled and non-scheduled injuries, the losses are converted to whole person and compensated as combined medical impairment benefits. *Mountain City Meat Co. v. Oqueda*, 919 P.2d 246 (Colo. 1996).

INDEMNITY BENEFITS FOR MINORS

A minor is defined as any person who has not attained the age of twenty-one years. *See* C.R.S. § 2-4-401(6). The age on the date of injury is the factor used to determine if the claimant is considered a minor for the entire claim. Benefits are paid in the same time frames as in the case of adults.

Where an employee is a minor and the disability is temporary, the average weekly wage of such minor shall be determined by the division as in cases of disability of adults. Where the disability of such minor is permanent or if benefits under articles 40 to 47 of this title accrue because of the death of such minor, compensation to said minor or death benefits to said minor's dependents shall be paid at the maximum rate of compensation payable under said articles at the time of the determination of such permanency or of such death.

C.R.S. § 8-42-102(4)

TEMPORARY DISABILITY BENEFITS FOR MINORS

The AWW is determined and TTD and TPD benefits are calculated as in the case of adults.

PERMANENT IMPAIRMENT BENEFITS FOR MINORS

- **Scheduled Impairment - Minors**

The fixed rate for scheduled injuries is determined based on the date of injury per statute. Calculation is the same as for adults. *See Williams v. Industrial Claims Appeals Office*, 932 P.2d 869 (1997).

Number of weeks specified on the schedule for the body part x impairment rating x statutory amount = PPD award.

- **Non-Scheduled (Whole Person) Impairment - Minors**

For dates of injury on or after July 1, 1991, the PPD award is calculated using the maximum TTD rate in effect at the time of MMI (not the maximum TTD rate in effect on the date of injury as in adult cases).

The age factor used is the age of the claimant on the date of MMI. (Note: The claimant's status as a minor at the time of injury does not change although the claimant may be 21 years or older at the time of MMI.)

Calculation of medical impairment benefits of injuries not on the schedule:

Medical impairment rating x age factor x 400 weeks x maximum TTD rate at the time of MMI = PPD award.

See Arkansas Valley Seeds v. Industrial Claims Appeals Office, 972 P.2d. 695 (1998).

STATUTORY OFFSETS

Offsets are allowed so that a claimant does not receive duplicate benefits designed for the same purpose. *See* C.R.S. § 8-42-103 and Rule 6-5. Offsets may not reduce benefits below zero.

Based on certain conditions, offsets may be taken for disability, retirement, unemployment, and workers' compensation benefits received from another state or the federal government.

- ✓ **DISABILITY BENEFIT OFFSETS**

Offsets for disability payments may be taken against TTD, TPD, PPD, and PTD benefits. *See* C.R.S. 8-42-103(1).

Generally, reduction in benefits equal to 50% of Social Security disability benefits is allowed. The offset percentage for an employer paid disability plan is the percentage of the employer's contribution.

- **Social Security Disability Benefit Offset**

Only the original Social Security award is subject to offset. The social security cost-of-living increases should not be included when determining the amount of the weekly benefit awarded. When a claimant receives a retroactive lump sum of Social Security benefits, only the net amount of the award, after subtracting the attorney fees, may be offset. The weekly benefit amount of the Social Security award is multiplied by 50%. This amount is then deducted from the claimant's weekly compensation payment.

Initial monthly (SSDI award x 12) ÷ 52 x 50% = Amount of offset per week

Weekly TTD, PPD, or PTD Benefit - Amount of offset = Weekly benefit rate

- **Employer-paid Disability Benefit Offset**

The disability offset is calculated by multiplying the claimant's weekly disability benefits by the percentage of the employer's contribution to the disability plan. This amount is then deducted from the weekly worker's compensation payment.

- **Firefighters' and Police Officers' Pension Reform Act (FPPA) Offset**

Workers' compensation benefits may be eligible for offset or reductions by FPPA disability pension paid pursuant to article 30.5 or 31, of title 31 C.R.S. The reduction shall not reduce the combined weekly disability benefits below a sum equal to one hundred percent of the state average weekly wage as defined in § 8-47-206 and applicable to the year in which the weekly disability benefits are being paid. Whether benefits are subject to offset should be re-evaluated every July 1 when there is a change in the state average weekly wage and whenever there is a change in the FPPA award.

✓ RETIREMENT BENEFIT OFFSETS

Offsets for retirement payments may only be taken against PTD benefits, and the claimant must have reached the age of forty-five years at the time of the injury on which the PTD award was based. *See* C.R.S. § 8-42-103(1)(c). Note the deletion of reference to a specific age of retirement for purposes of the offset against permanent total disability benefits in 2000. *See* HB00-1383, modifying C.R.S. § 8-42-103.

The offset percentage for an employer-paid retirement plan is the percentage of the employer's contribution.

- **Social Security Retirement Benefit Offset**

The initial weekly benefit amount of the Social Security retirement benefit is multiplied by 50%. This amount is then deducted from the claimant's weekly PTD benefit payment.

$$\text{Initial monthly Social Security retirement benefit} \times 12 \div 52 \times 50\% = \text{Amount of offset per week}$$

$$\text{Weekly PTD Benefit} - \text{Amount of offset} = \text{Weekly benefit rate}$$

- **Employer-paid Retirement Benefit Offset**

The retirement offset is calculated by multiplying the claimant's weekly retirement benefits by the percentage of the employer-paid retirement benefits. This amount is then deducted from the claimant's weekly PTD benefit payment.

$$\frac{\text{Employer's contribution during covered employment} + \text{Total contribution during covered employment}}{\text{Employer's percentage of contribution}}$$

$$\text{Employer's percentage of contribution} \times \text{weekly retirement benefit} = \text{Amount of offset per week};$$

$$\text{Weekly PTD Benefit} - \text{Amount of offset} = \text{Weekly benefit rate}$$

There is an exception in PTD cases that all employer contributions are considered to be made by the employee if

the result of collective bargaining. *See* C.R.S. § 8-42-103(1)(c)(II)(B).

✓ **SUPPLEMENTAL SECURITY INCOME (SSI)**

SSI benefits are not offsettable against any workers' compensation benefits. SSI is a federal income program funded by general tax revenues not Social Security taxes. The program helps aged, blind, and disabled persons who have little or no income by providing monthly payments to meet basic needs.

✓ **UNEMPLOYMENT COMPENSATION OFFSET**

An offset may be taken against permanent total disability and temporary disability benefits for the amount of unemployment benefits received, but benefits may not be reduced below zero. If the claimant's unemployment benefits have already been reduced by reason of receipt of temporary disability benefits, then the temporary disability benefits may not be reduced. There is no offset against PPD benefits. *See* C.R.S. § 8-42-103(1)(f).

✓ **OFFSET DUE TO WORKERS' COMPENSATION BENEFITS FROM ANOTHER STATE OR FEDERAL GOVERNMENT**

An offset may be taken to the full extent of workers' compensation benefits received under the law of another state or the federal government. *See* C.R.S. § 8-42-103(1)(e).

TIPS

✓ **CALCULATION OF PERMANENCY WHEN SOCIAL SECURITY DISABILITY INSURANCE (SSDI) BENEFITS APPLY**

An SSDI offset against whole person impairment should be calculated as follows in accordance with *Armijo v. ICAO*, 989 P.2d 198 (Colo. App. 1999).

1. Determine the pre-offset PPD award pursuant to § 8-42-107(8)(d) by multiplying the medical

impairment rating by the age factor by 400 weeks by the TTD rate.

2. Determine the weekly offset amount by multiplying the original SSDI monthly award by 12, divide by 52 and multiply by 50%.
3. Determine the number of weeks of the payout period by dividing the PPD award by the PPD payout rate. The PPD payout rate is the TTD rate but not less than \$150 per week and not more than 50% of the state AWW for the date of injury.
4. Deduct the SSDI weekly offset amount from the weekly PPD payout rate to determine the weekly benefit amount.
5. Multiply the weekly benefit amount by the number of weeks of the payout period.

VII. PAYING INDEMNITY BENEFITS

TEMPORARY BENEFITS

The initial payment of temporary benefits must be paid immediately upon admission for benefits. *See* C.R.S. §8-43-203(2)(b)(I). Benefits should be paid at least through the date of the check unless benefits were terminated in accordance with Rule 6, to avoid potential disputes over whether payment is in arrears.

Benefits must be paid at least once every two weeks. *See* C.R.S. § 8-42-105(2)(a).

The waiting period must be paid when a claimant's period of disability lasts longer than two weeks from the day the claimant leaves work as a result of the injury. *See* C.R.S. § 8-42-103(1)(b). Benefits are calculated based on a 7-day week.

TIPS

- ✓ The initial payment of temporary benefits awarded by admission is due on the date of the admission and through the date of the check unless benefits were terminated pursuant to Rule 6.
- ✓ Pursuant to Rule 6, temporary benefits may be terminated, modified, or suspended without a hearing only if certain conditions are met and an admission is filed with applicable supporting documentation. An admission with supporting documentation must be filed by the date the periodic payment is due or payment must continue. *See* Rule 6 discussion in Section V, page 18. *See, also*, Rule 5-5(C).
- ✓ Reaching the statutory limits does not trigger the condition allowing termination of temporary benefits. Temporary benefits are limited at either \$60,000.00 or \$120,000.00 for dates of injury occurring 7/1/91 through 12/31/05 and \$75,000.00 or \$150,000.00 for dates of injury occurring on or after January 1, 2006--only when the claimant has reached MMI and the amount of permanent impairment has been determined. This limitation applies to combined temporary and permanent impairment benefits, and permanent impairment can only be determined upon MMI. *See* C.R.S. § 8-42-107.5.

PERMANENT IMPAIRMENT BENEFITS

- Benefits for permanent impairment (PPD) are due on the date of the admission and every two weeks thereafter until paid in full.
- Benefits for PPD should commence on the date of MMI.
- The initial PPD payment should use the date of MMI as the first date of the time period and pay at least through the date of the admission to bring the payment current.
- Periodic payments of impairment benefits may not stop if the automatic lump sum of \$10,000.00 is paid, pursuant to C.R.S. § 8-42-107(8)(d).
- Credits are applied at the end of the payout period.

Rates for Permanent Impairment

Maximum Benefit Rates are available under the *Desk Aids* section of the Division web site.

Scheduled injuries are paid at the fixed compensation rate determined by the Director of the Division of Workers' Compensation each July 1st for dates of injury during that year. For dates of injury prior to July 1, 1999, the statutory rate for scheduled injuries is \$150.00 per week. For dates of injury July 1, 1999 through June 30, 2000, the rate is \$176.00 per week. Beginning July 1, 2000 and every year thereafter, the statutory rate is established by the Director.

Non-scheduled injuries are paid at the TTD rate, but not less than \$150.00 per week and not more than 50% of the State AWW in effect on the date of injury. When up to \$10,000.00 is requested by the claimant and paid in a lump sum less the 4% discount, the remaining periodic payments are paid at the TTD rate but not less than \$150.00 per week and not more than 50% of the State AWW at the time of injury, beginning on the date of MMI. See C.R.S. § 8-42-107(8)(d). The 4% discount is not a straight 4%. See Lump Sum Payments and Calculation of Discount, Chapter VIII.

DISFIGUREMENT BENEFITS

- Colorado law provides for disfigurement benefits up to \$2,000.00 if the claimant has permanent scarring or disfigurement on a body part normally exposed to public view. *See* C.R.S. § 8-42-108.
- Permanent disfigurement is indicated if a scar or disfigurement exists at least six months after the date of injury or last surgery.
- Public view is normally indicated by a scar or disfigurement that is visible when an individual is wearing a swimsuit.

Determination of the amount of Disfigurement Benefits

A claimant should contact the insurance carrier (or employer if there is no insurer) to request disfigurement benefits. If the claimant and insurer are unable to agree on an amount of disfigurement benefits, the claimant may submit photographs showing the scar or disfigurement to an administrative law judge for determination of disfigurement benefits.

An explanation of this procedure and the form used for submission of disfigurement benefits may be obtained from the Office of Administrative Courts.

VIII. LUMP SUM PAYMENTS & CALCULATION OF DISCOUNT

LUMP SUM PAYMENTS OF PERMANENT IMPAIRMENT AWARD

Lump sum payments are governed by C.R.S. §§ 8-42-107(8) and 8-43-406. Rule 5-10 outlines procedures for requests and payment of lump sum awards.

Lump sum awards may be requested for permanent impairment benefits (PPD), permanent total disability (PTD) benefits, or dependents' benefits. The maximum amount of a lump sum award that can be granted is dependent upon the date of injury. The discount for a lump sum is not a straight 4%. The amount of the lump sum is based on the present worth of periodic partial payments, considering interest at four percent per annum, and less a deduction for the contingency of death. The Claims Management Unit can provide lump sum discount calculations. A table outlining the 4% discount on \$10,000 is available under the *Desk Aids* section of the Division website.

A discount may not be taken unless the claimant requests payment for a lump sum in writing. The carrier may choose to pay a lump sum without discount absent a request from the claimant.

Payment of any remaining PPD benefits following a lump sum award must continue to be made every two weeks until the PPD award is paid out, taking into consideration the credit for the lump sum award.

Lump Sums for Non-Scheduled Impairment

For non-scheduled injuries, upon written request to the carrier, up to \$10,000.00 of partial payments shall be paid to the claimant less the discount of 4% per annum. *See* Calculating Lump Sums of \$10,000 or Less, under the *Desk Aids* section of the Division website.

A lump sum award in an amount up to \$37,560.00 may be granted by order of the Director after the claimant and the carrier complete an Application for Lump Sum form. An agreement to the rating is a prerequisite for the Director to approve a lump sum payment.

A lump sum may be issued based on a Final Admission that is disputed on an issue other than the non-scheduled impairment award. However, the claimant must agree to the admitted impairment award in order to be granted a lump sum. The Application for Lump Sum form (revised 8/02) contains language stating that the claimant agrees to the impairment award.

A lump sum may also be granted if a carrier filed a Final Admission based on a Division Independent Medical Examination (DIME) result and the claimant disputes the impairment award. If a carrier admitted liability consistent with the DIME findings, payment must be made in accordance with the admission. The claimant may challenge DIME results, based on a belief that there is greater impairment, but must overcome the opinion with clear and convincing evidence. If the carrier disagreed with the DIME, the carrier had the option of setting the matter for hearing rather than admitting to the DIME rating.

When the claimant asserts a claim for permanent total disability, the Director may consider an Application for Lump Sum on benefits awarded in the Final Admission. *See* Rule 5-10(C)(3).

Lump Sums for Scheduled Impairment

For scheduled injuries, requests for a lump sum payment of the PPD award requires an Application for Lump Sum be completed by the claimant and the carrier and forwarded to the Division for an order. An agreement to the rating is not a prerequisite.

A claimant seeking a lump sum for a scheduled impairment is not limited to payment of the initial \$10,000.00 from the carrier, but "may request a lump sum payment for the entire award up to the maximum...." *See* Rule 5-10(D).

IX. CLOSING A CLAIM

By Final Admission

A claim is automatically closed as to the issues admitted if there is no objection to the Final Admission of Liability filed by the claimant within the statutory time period. *See* C.R.S. § 8-43-203(2).

By Settlement

A claim is closed by agreement of the parties to a full and final settlement approved by the Director or an administrative law judge. *See* C.R.S. § 8-43-204.

By Order

Adjudicated issues in a claim may be closed upon the final order of an administrative law judge. *See* C.R.S. § 8-43-207.

By Rule

When no action in furtherance of prosecution has occurred for at least six months, a petition to close a claim may be filed with the Director. *See* Rule 7-1(B).

After receipt of a Motion to Close pursuant to Rule 7-1(B)(2), the Director will issue an Order to Show Cause why the claim should not be closed. For dates of injury on or after March 1, 1992 (the effective date of the current rule), if there is no response from the claimant within the designated time, the claim will close automatically.

Final Payment Notice

Pursuant to Rule 5-11(B), a Final Payment Notice (WC25) must be filed after all compensation issues have been resolved by final admission, final order or stipulation. The final payment notice must be filed 60 days after the claim is closed.

X. REOPENING A CLAIM

Either the claimant or the carrier may file a Petition to Reopen. Complete Division form WC37 and send a copy to the Division and the opposing parties.

Claimant's Petition to Reopen

The carrier reviews the information on a Petition to Reopen (WC37) and informs the claimant and the Division whether the claim will be voluntarily reopened. Filing a General Admission informs all parties that the claim is reopened. The admission should list all previously-admitted benefits. If the claim is not voluntarily reopened, the claimant may apply for a hearing. *See* Rule 7-3.

Carrier's Petition to Reopen

For dates of injury after July 1, 1991, a carrier or self-insured employer may petition to reopen an award of permanent total disability benefits based upon a request to terminate permanent total disability benefits. *See* C.R.S. § 8-43-303(3). The petition shall contain a statement of the basis for the request. *See* Rule 7-3(A).

XI. HOW TO AVOID AN ERROR LETTER

The Division carefully reviews admissions for completeness, accuracy, and supporting documentation. If an admission is deficient in one or more of these areas, an Error Letter is sent to the claims handler to correct the deficiency. Avoid Error Letters by following these tips:

- ✓ If an AWW is different from what is listed on the First Report of Injury and/or the Worker's Claim for Compensation, send documentation to support the admitted AWW with the first admission for benefits.
- ✓ Use the AWW calculation worksheet.
- ✓ Check the calculation of the TTD rate. It must be $\frac{2}{3}$ of the admitted AWW up to the maximum compensation rate in effect on the date of injury.
- ✓ Check all TTD dates and totals twice to confirm accuracy.
- ✓ If applying an offset, the documentation and the calculations must be attached to the admission.
- ✓ Document termination of any type of temporary benefits (TTD and TPD) pursuant to Rule 6.
- ✓ If terminating temporary benefits per Rule 6, all components of one of the subsections of the Rule must be satisfied, and documentation must be sent with the admission.
- ✓ If terminating benefits based on a supplemental report, verify it is properly signed by either the claimant, the employer, or both.
- ✓ Verify that the time period admitted corresponds to the time period listed on the supplemental report.
- ✓ Do not reduce the TTD rate once admitted without petitioning per Rule 6-4 or documenting the basis for an offset.
- ✓ Double check the calculation of PPD benefits and list the PPD calculations on the admission.

- ✓ Double check the age at MMI. Verify that the correct age factor is used.
- ✓ Set the decimal on the calculator to F (floating).
- ✓ If the waiting period was not originally paid and temporary benefits have been paid for longer than two weeks, pay the waiting period and file a new admission reflecting admission for the waiting period.
- ✓ If the claimant was a minor at the time of the injury and has been placed at MMI with a non-scheduled impairment rating, verify that the PPD is calculated based on the maximum TTD rate in effect at the time of MMI.
- ✓ Send written documentation of the TPD rates and periods. Use a TPD worksheet to document the TPD benefits admitted and paid.
- ✓ Attach the medical report used as the basis for MMI and PPD to all admissions, even if the PPD award is based on a Division IME.
- ✓ Apply the cap of \$60,000/\$120,000 (for dates of injury occurring July 1, 1991 through December 31, 2005) or \$75,000/\$150,000 (for dates of injury on or after January 1, 2006), once the claimant reaches MMI and list only the PPD benefits to be paid.

If a letter is received from the Division, immediate response is imperative. Call the Claims Manager to resolve any questions regarding the request, including disputes whether proper documentation had already been sent.

See C.R.S. § 8-43-218(3).

XII. ACRONYMS

The workers' compensation system uses many acronyms and abbreviations. A list of acronyms and their meanings are included.

ALJ	Administrative Law Judge with OAC
ATP	Authorized Treating Physician
AWW	Average Weekly Wage
CDLE	Colorado Department of Labor & Employment
COLA	Cost of Living Adjustment
CRS	Colorado Revised Statutes
DIME	Division Independent Medical Evaluation
DOB	Date of Birth
DOI	Date of Injury
DOWC	Division of Workers' Compensation
EDI	Electronic Data Interchange
FA	Final Admission of Liability
FEIN	Federal Employer Identification Number
FROI	First Report of Injury
FPN	Final Payment Notice
GA	General Payment Notice
ICAP/ICAO	Industrial Claim Appeals Panel
IME	Independent Medical Examination
MMI	Maximum Medical Improvement
MMIF	Major Medical Insurance Fund
NCCI	National Council on Compensation Insurance
OAC	Office of Administrative Courts
PALJ	Administrative Law Judge with DOWC Prehearing Unit
PERA	Public Employees Retirement Association
PHC	Prehearing Conference
PPD	Permanent Partial Disability
PTD	Permanent Total Disability
SIF	Subsequent Injury Fund

SSDI	Social Security Disability Income
SSN	Social Security Number
SROI	Subsequent Report of Injury (an EDI term)
TPA	Third Party Administrator
TPD	Temporary Partial Disability
TTD	Temporary Total Disability
UR	Utilization Review
WCC	Workers' Claim for Compensation
WC#	Division assigned Workers' Compensation No.

XIII. DESK AIDS

The following desk aids are available in their entirety on the Division web site at: <http://coworkforce.com/DWC/> and can be viewed, printed, and downloaded in Microsoft Word or Adobe Acrobat (a free software viewing program).

- Average Weekly Wage Worksheet
- Calculating Lump Sum Discounts on \$10,000 or Less
- \$10,000 Lump Sum 4% Discount Table
- Maximum Benefit Rates
- Age Factor Chart
- Scheduled Injuries Table
- Temporary Partial Disability (TPD) Benefit Worksheet

XIV. PHONE NUMBERS

DIVISION OF WORKERS' COMPENSATION CUSTOMER SERVICE UNIT

**633 17th Street, Suite 400
Denver, CO 80202-3660**

303.318.8700

Toll-free number 1.888.390.7936

Si tiene preguntas o necesita información, llame a nuestro número sin peaje a 1.800.685.0891

**Special Funds Unit
Major Medical, Subsequent Injury, and Medical Disaster
Funds**

Toll free number 1.800.453.9156

Prehearing Conference Unit 303.866.5527

Internet Address:

<http://coworkforce.com/DWC/>

OTHER GOVERNMENT OFFICES

Office of Administrative Courts	303.866.2000
Division of Insurance	303.894.7499
Mine Safety and Health Administration	303.231.5400
Occupational Safety and Health Administration	
● Denver area employers	303.844.5285
● All other employers	303.843.4500
Unemployment Insurance Tax	
● Toll-free number (in state)	800.480.8299
● Denver metro area	303.603.8231

XV. PUBLICATIONS

The Division of Workers' Compensation offers a variety of materials to the public regarding the system it administers. Publications are available on the Division's Web Page at <http://www.coworkforce.com/DWC/> or can be requested by calling the Customer Service Unit.

- *Overview of the Division of Workers' Compensation*
- *Workers' Compensation Guide for Employees*
- *Workers' Compensation Guide for Employers*
- *Workers' Compensation Guide for Adjusters*
- *Essentials of the Workers' Compensation Premium Cost Containment Program and Employer Certification*
- *Workers' Compensation Loss Prevention and Loss Control Program Manual*
- *Self-Insurance Information and Application*
- *Dispute Resolution Services*
- *Workers' Compensation Act*
- *All About Claims Newsletter*
- *Interpretive Bulletins*
- *Brochures*
- *Workers' Compensation Insurance Requirements for Employers*
 - *Customer Service*
 - *Independent Medical Examination*
 - *Special Funds*
 - *Subsequent Injury Fund*
 - *Major Medical Insurance Fund*
 - *Electronic Data Interchange*
 - *Medical Policy and Research*

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