



COLORADO

Department of
Labor and Employment

Division of Workers' Compensation

ADJUSTER'S GUIDE



July 2015

**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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TABLE OF CONTENTS

I.	INTRODUCTION	1
II.	USE OF DIVISION FORMS	3
III.	ESTABLISHING A CLAIM WITH THE DIVISION	5
IV.	FILING A POSITION STATEMENT	6
	Notice of Contest.....	6
	General Admission	7
	Final Admission.....	9
	General Fatal Admission.....	14
	Final Fatal Admission	14
V.	TERMINATION/MODIFICATION OF TEMPORARY BENEFITS.....	19
	Unilateral Termination/Modification of Temporary Benefits per Rule 6.....	19
	Petition to Suspend, Modify, or Terminate Temporary Benefits.....	22
VI.	CALCULATING INDEMNITY BENEFITS.....	25
	Temporary Disability Benefits.....	25
	Permanent Impairment Benefits.....	26
	Indemnity Benefits for Minors	28
	Statutory Offsets.....	29
VII.	PAYING INDEMNITY BENEFITS	34
	Temporary Benefits.....	34
	Permanent Impairment Benefits.....	35
	Disfigurement Benefits	35
VIII.	MEDICAL PAYMENTS	37
IX.	MEDICAL TREATMENT GUIDELINES.....	39
X.	DIVISION INDEPENDENT MEDICAL EVALUATION PROCESS (DIME).....	41
XI.	LUMP SUM PAYMENTS OF PERMANENT PARTIAL, PERMANENT TOTAL & DEPENDENT'S BENEFITS	42
XII.	CLOSING A CLAIM	45
XIII.	SETTLEMENTS.....	46
XIV.	REOPENING A CLAIM.....	48

XV. HOW TO AVOID AN ERROR LETTER	49
XVI. ACRONYMS.....	52
XVII. DESK AIDS.....	55
XVIII. PUBLICATIONS	55
XIX. PHONE NUMBERS.....	56

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 is responsible for the administration of the workers' compensation system in Colorado.

This guide is offered as a resource 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 affects benefits related to the claim.

Although this guide primarily addresses paper forms, the information can also be applied to electronic transmissions. The Division encourages the use of Electronic Data Interchange (EDI) using the International Association of Industrial Accident Boards and Commissions (IAIABC) format. Electronic transmissions of First Reports of Injury and Notices of Contest are required.

The Colorado Division of Workers' Compensation hosts a website at www.colorado.gov/cdle/dwc where Division information, publications, rules, statutes, notices, and commonly used forms may be accessed. Forms are available in Word and fillable PDF formats and can be downloaded or printed. Please refer to the Division website for the most current versions.

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 and Rules of Procedure are available on the Division

website. A copy of the Workers' Compensation Act may also be obtained from Customer Service.

If you have further questions, please call Customer Service at 303-318-8700. Additionally, we can provide training tailored to meet the specific needs of an organization. Please call Claims Management at 303-318-8600 to schedule training.

II. USE OF DIVISION FORMS

It is imperative that claims handlers use current Division forms. The Division website (www.colorado.gov/cdle/dwc) contains the most current version of commonly used forms. All forms filed with the Division must meet the following minimum requirements or they cannot be processed:

- Type or print legibly in blue or black ink
- Complete all applicable fields
- Use the most current version of the form
- List Workers' Compensation number (WC#) on all position statements

See Rules 5-1(4), 5-3, 5-13.

Block Numbers and TPA Codes

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

All third-party administrators (TPAs) are assigned two-letter adjusting codes. This code must be included on all filings made with the Division by a TPA. If a carrier adjusts claims at different locations, the proper adjusting code must be utilized to identify each location in order for mail to be directed to the correct office.

A TPA may be designated on a First Report of Injury, a Notice of Contest, or an Admission. The Division will not send correspondence to the TPA until such a designation is made.

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.

All Employers' First Report(s) of Injury must be filed with the Division electronically. See C.R.S. § 8-43-101 and Rule 5-1(B) and (C). An accurate Insurer FEIN (Federal Employer Identification Number), TPA (if applicable), and employer name must be transmitted.

All documents filed with the Division after the initial filing must include the WC#. Documents cannot be processed without the WC#. Failure to include the correct WC# may result in filings being rejected and/or the imposition of penalties.

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 to the employer that a work-related accident resulted in any of the following:

- Lost time in excess of three shifts or calendar days
- Permanent impairment
- Contraction of an occupational disease that has been listed by rule
- Denied claim

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, the carrier, third-party administrator, or self-insured employer must electronically transmit an Employer's First Report of Injury to the Division.

If a claim is established with the Division through a Worker's Claim for Compensation (WC15) or Dependent's Notice and Claim for Compensation (WC18), the carrier, self-insured employer, or non-insured employer identified from Division records will be provided a copy of the claim by mail. If a TPA will be used, it is the responsibility of the carrier, self-insured employer, or non-insured employer to forward the claim to the TPA.

Upon acceptance of a First Report, Worker's Claim, or Dependent's Notice, the Division will assign a Workers' Compensation number (WC#).

IV. FILING A POSITION STATEMENT

TIMELINE

A position statement (either a *Notice of Contest* or an *Admission*) 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 Dependent's Claim, a position statement must be filed within 20 days after the Division mails a copy of the claim to the insurer.

Section 8-43-203(3) of the Colorado Revised Statutes provides, in part, that at the time an admission or denial is filed, the insurer must provide to the claimant a brochure written in easily understood language and in a form developed by the director, that describes the claims process and informs the claimant of his or her rights.

Pursuant to Rule 5-5(C), a subsequent admission that terminates or reduces benefits must be filed prior to the next scheduled indemnity payment due date.

NOTICE OF CONTEST

A *Notice of Contest* (WC74) is filed to deny liability for a workers' compensation claim. A *Notice of Contest* must be filed electronically via electronic data interchange (EDI) with the Division, and by hard copy with all other parties. **DO NOT file a Notice of Contest on a previously admitted claim.**

TIPS

Since denial of a claim may have serious economic impact on a 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 in some instances.

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 workers' 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).

Subsequent admissions must be filed at any time when there is a change in temporary benefits (either terminating or reducing), even if the change was the result of an order. If the benefit rate is decreasing, a Petition to Modify pursuant to Rule 6-4 must be filed if applicable. The admission must be filed prior to the next scheduled indemnity payment due date. If the rate is increasing, the admission must be filed within 30 days of the change. See Rule 5-5(C).

TIPS

Supporting documentation for termination/modification

See Termination/Modification of Temporary Benefits in Section V, 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 does not need to 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 clarifying benefits.

Filing subsequent admissions

Subsequent admissions must be submitted with a Division assigned WC#. The WC# for a claim transmitted via EDI is assigned and submitted to the carrier electronically. Check internal company procedures on how to access the assigned WC#.

All subsequent admissions must reflect all benefits previously admitted. Only benefits that are statutorily owed should be listed in the Benefits History section of the admission.

Benefits admitted and paid may not be recovered or withdrawn without an order issued by an Administrative Law Judge (ALJ), or a Stipulated Agreement between all parties.

An ALJ may order retroactive recovery of overpaid benefits.

A carrier may petition to modify future benefits under Rule 6-4.

See Termination/Modification of Temporary Benefits in Section V, 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 workers' compensation claim to specifically delineate all benefits for which liability is admitted on the claim. The Final Admission notifies the claimant of what action must be taken if the claimant disagrees with the admission and includes applicable deadlines for filing an objection. If the claimant does not timely object, then the issues addressed in the admission become final, and 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

Within 30 days of the date of mailing or delivery of a medical report from the authorized treating physician, there are three (3) choices:

- File a *Final Admission of Liability*;
- Request a *Division Independent Medical Exam (DIME)*; or
- File an *Application for Hearing*.

TIPS

Failure to timely request a DIME waives the right to contest the impairment rating. If the request isn't filed within thirty days, the insurer must admit for the rating provided.

A DIME is not required for a scheduled impairment. Any dispute regarding only a scheduled impairment can proceed straight to hearing. However, the claimant may request a DIME on the issue of MMI and/or conversion to a Whole Person Impairment.

TIPS

Certificate of Mailing

The Final Admission must be placed in the mail or delivered on the date listed in the certificate of mailing, as this 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. Correct certification is important because by statute, the claimant has 30 days from this date to object to the Final Admission.

Re-filing a Final Admission

If an admission is re-filed, 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. Failure to do so will affect the claimant's right to timely object and consequently, the ultimate 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 listed specifically and reserved against future benefits 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 or ordered by an Administrative Law Judge (ALJ).

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, or clerical error. *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.

Filing a Final Admission for Abandonment of Claim

A Final Admission may be filed based on abandonment of a claim if claimant is not receiving TTD benefits with the following attachments:

- Documentation of two consecutive missed medical appointments
- A copy of the 30 day letter sent to the claimant and claimant's attorney after the second missed appointment, asking if further medical treatment is required and whether the injured worker is claiming permanent impairment

In bold capital letters, the letter must state "FAILURE TO RESPOND TO THE LETTER WITHIN 30 DAYS WILL RESULT IN A FINAL ADMISSION BEING FILED." If the claimant responds timely to the letter, the carrier may not file a Final Admission pursuant to Rule 7-1(B).

Per Rule 7-1(E), a Final Admission may be filed based on voluntary abandonment of a claim if the claimant is not receiving TTD benefits. The Final Admission must include the following attachments:

- Written acknowledgment by the claimant upon a form prescribed by the Division that the claimant is abandoning current and future medical care related to the claim. The Voluntary Abandonment of Claim form (WC191) may be found under the Forms section on the Division website.

- Verification that the claimant received written notice of the reopening provisions of C.R.S. § 8-43-303.

The claimant may object to a Final Admission filed pursuant to Rule 7-1(E).

Final Admission Checklist

- Complete the form completely and accurately. Rule 5-1(A).
- State the MMI date accurately (the start date of PPD benefits is the date of MMI).
- Check all benefits for which liability is admitted and include total dollar amounts for each type of benefit in the *Benefit Summary* section.
- If a stipulation has been reached and approved, do not list it in the *Benefit History* section. Instead, it should be listed in the *Benefit Summary* section on the line titled: "Stipulation \$"
- When completing the Benefit Summary, Medical to Date (total) \$ should only include medical expenses, not legal fees paid or any non-medical expenses.
- Verify that the PPD rating was issued by a Level II-accredited physician or that a statement of "no impairment" was issued by an authorized treating physician providing primary care. If the MMI report is issued by someone other than an authorized treating physician (i.e. a nurse practitioner, a physician's assistant, etc.), it must be countersigned by an authorized treating physician.
- Record any impairment information in the PPD section. Complete the Whole Person or Scheduled Impairment section (or both, if applicable – see *Calculating Indemnity Benefits* in Section VI to determine when to combine Whole Person and scheduled impairments) including the percentage of impairment. Provide the claimant's age on the date of MMI if a Whole Person rating is admitted. Provide the Part of Body Code if a Scheduled rating is admitted. See page 2 of the admission to verify the correct Part of Body Code.

- State a position on medical benefits after MMI, in easy-to-understand language, under the *Remarks* section of the Final Admission.
- Describe any offsets against benefits in the Remarks section and show how the offsets were calculated.
- 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)(1). It is helpful to include the calculations for the award. See Calculating Indemnity Benefits in Section VI.
- List all admitted permanent impairment benefits completely, including time periods, rates, and totals in the *Benefit History* section. Only the benefits that have been or will be paid should be listed in this section.
- If benefits are limited by the statutory cap, benefits should equal the applicable cap in the *Benefit History* section and the remarks should specify the cap that is applied, per §8-42-107.5. Even if PPD has been paid in a lump sum, the information in the Benefit History section must include time periods, rates, and totals. This is required because the statute of limitations runs from the last day PPD is due and payable, if paid biweekly.
- Only benefits that are statutorily owed should be listed in the *Benefit History* section. Any overpayments for benefits paid past the proper termination date should be outlined in the remarks section, in addition to an explanation of how the amount will be recovered.
- Identify the Claims Representative's name, local phone number, toll-free phone number, and self-insured employer, carrier, or TPA address.
- Certify the actual date the document is placed in the U.S. mail or delivered on the admission or certificate of mailing.
- Submit all required copies to the parties of interest. Copies of each admission must be filed with the claimant, the employer, legal counsel (if any), and the Division.
- Provide the signature of the individual certifying

- mailing or delivery of the document.
- Check for an accurate Block Number and TPA code.
- Provide all required attachments:
- All four pages of the Final Admission with the requisite attachments must be sent to all parties.
- Support for termination or modification of temporary benefits must be included.
- MMI report and physician's medical report, including worksheets, must be attached.

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) may be filed when:

- All issues have been addressed and notice of appeal rights are provided;
- The deceased worker leaves no statutory dependents and payment of \$15,000 is made to the Subsequent Injury Fund;
- All dependents' benefits have been paid

Adjusters with questions on a fatality claim are encouraged to contact the Division claims manager assigned to the claim for assistance in ensuring compliance.

TIMELINE

The employer/carrier is required to contact the Division's Customer Service unit at 303-318-8700 within 24 hours of receiving notice, in addition to filing a First Report of Injury. See C.R.S. § 8-43-103(1) and Rule 5-2(B) (1).

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 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. If a Dependent's Claim is filed, 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 *Employer's 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 *Dependent's 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 *Dependent's Notice and Claim for Compensation* is received on a claim where there is a pre-existing 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 Dependent's Notices 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 at sixty-six and two-thirds of the deceased employee's average weekly wage. The maximum benefit rate in effect at the time of death is the rate on the date of injury, or in the case of occupational disease, the date of last injurious exposure and this applies to dependents' 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.* A minor is a person under the age of 21. See C.R.S. § 2-4-401(6).

There is a minimum death benefit rate. The minimum death benefit is 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 per week at the time of death, the compensation rate for an injury claim would be \$140 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 the 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 individuals who are wholly dependent (such as a spouse or minor child).

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 **unless** the deceased is a minor with no dependents. In such cases, \$15,000 shall be paid to the parents of the deceased. A minor is a person under the age of 21. See C.R.S. § 2-4-401(6).

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

Closure of a claim for dependents' benefits

Closure on a fatal claim follows the same process as closure for an injury claim. Whenever a *Final Admission of Liability* is filed that 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(C). Questions with regard to closures of these claims may be forwarded to the Division's Claims Management unit.

TIPS

Claim established prior to death

If a claim has been established and the claimant dies while receiving benefits, a Final Admission terminating temporary benefits may be filed with either a death certificate or supporting document indicating the claimant's date of death. A position must be taken by the carrier/TPA regarding liability for death benefits.

The carrier/TPA has 20 days to file a position on liability.

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 the dependents (if any) as determined by the Director or Administrative Law Judge (ALJ). If there are no dependents, the Director may order unpaid benefits be applied to other expenses, preferably funeral expenses. C.R.S. § 8-41-503.

Claimant receiving PPD benefits at the time of death

Where death is not the proximate result of the injury and permanent partial disability (PPD) benefits have been admitted, the unpaid portion of PPD benefits is due and payable to any dependents. *See* C.R.S. §§ 8-42-116(b) and 8-42-117(b). Where death resulted from the injury, refer to C.R.S. § 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.” C.R.S. § 8-42-116(1)(a). If partial dependents remain, refer to C.R.S. § 8-42-117(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 OR REDUCTION OF TEMPORARY BENEFITS PURSUANT TO RULE 6

When temporary disability benefits are terminated or modified, an admission must be filed prior to the next scheduled date of payment. 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:

Termination for attainment of MMI; release or return to work; offer of modified duty employment; failure to appear at a rescheduled appointment; or death, per Rule 6-1 (A) must include:

- A 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).
- A medical release to return to regular employment. Rule 6-1(A)(2).
- A signed statement by employer or employee of return to work at full wages. Rule 6-1(A)(3).
- A signed statement by employer or employee of return to work at reduced wages and admission for TPD benefits, if any. Rule 6-1(A)(3).
- A letter to the claimant or copy of a written offer delivered to the claimant with a signed certificate indicating service, containing both an offer of modified employment, setting forth duties, wages and hours, and a statement from an authorized treating physician that the employment offered is within the claimant's physical restrictions. A copy of the written inquiry to the treating physician shall be provided to the claimant by the insurer or the insured at the time the authorized treating physician is asked to

provide a statement on the claimant's capacity to perform the offered modified duty. The claimant is allowed a period of 3 business days to return to work in response to an offer of modified duty. The 3 business days runs from the date of receipt of the job offer. Such admission of liability shall admit for temporary partial disability benefits, if any. Rule 6-1(A)(4).

- 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. Rule 6-1(A)(5).
- Death certificate or letter and statement of position on liability for death benefits. Rule 6-1(A)(6).

Termination for failure to respond to an offer of modified duty employment per Rule 6-1(A)(4), must include:

Written offer of modified duty that:

- is sent by certified mail or confirmation of the delivery of the offer by a signed certificate of service;
- sets forth duties, wages, hours, and
- is accompanied with a statement by an authorized treating physician stating the modified employment is within the claimant's physical restrictions; with-
- a copy of the written inquiry to the physician that 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).

Termination for failure to appear at a rescheduled appointment per Rule 6-1(A)(5), must include:

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; and
- advised that 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
- includes documentation from the physician that the claimant failed to appear.

Termination or modification based on a statutory offset per Rule 6-5 must include:

- 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). See Statutory Offsets.

Termination based on confinement per Rule 6-6 must include:

- a certified copy of a mittimus or court document establishing confinement due to conviction.

Termination or modification due to a third party award per Rule 6-7 must include:

- 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.

Termination for failure to respond to an offer of modified employment from a temporary help contracting firm per Rule 6-9 must include:

- 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 that 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.

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). 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 a 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 Return to Work

The Supplemental Report of Return to Work 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 a 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.

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 or she 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 terminated by the employer for cause. Termination must be sought under Rule 6-4, *Suspension, Modification or Termination of Temporary Disability Benefits, by a 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. Explain the distribution of benefits in the Remarks section of the admission or provide a letter to all parties.

VI. CALCULATING INDEMNITY BENEFITS

TEMPORARY DISABILITY BENEFITS

There are two types of temporary disability benefits: temporary total disability and temporary partial disability. 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 has lost time from work in excess of three days or three shifts.

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 *Employer's 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 a work injury, no wages are earned. All benefits are calculated and paid based on a 7-day week. Rule 5-6(E).

The temporary total disability (TTD) benefit rate is calculated at sixty-six and two-thirds percent of the claimant's AWW up to the maximum rate in effect for that date of injury. There is no minimum rate. C.R.S. § 8-42-105(1).

A weekly TTD rate is calculated by multiplying the AWW by sixty-six and two thirds up to the maximum rate in effect for the date of injury. 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 seven and multiply the result by the number of days of TTD owed.

(Note: The Benefit Calculator on the Division website may be used to calculate benefit rates, pay periods, lump sums, present value, offsets, etc. It can be found under the *Insurers* section at www.colorado.gov/cdle/dwc.)

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/or hours, and is earning less than the admitted AWW. Also, TPD benefits are due if the claimant has never left work, but due to restrictions, is unable to earn the admitted AWW.

The TPD rate should be calculated on a weekly basis by subtracting the gross weekly earnings from the AWW and multiplying the difference by sixty-six and two thirds up to the maximum rate in effect for the date of injury.

There is no minimum rate. Partial weeks are calculated on the basis of a 7-day week. C.R.S. § 8-42-106(1) and Rule 5-6(E).

The Temporary Partial Disability (TPD) Benefit Worksheet can be used to calculate TPD benefits and can be found at www.colorado.gov/cdle/dwc under "Publications and Desk Aids."

PERMANENT IMPAIRMENT BENEFITS

There are two types of permanent impairment benefits: scheduled impairment benefits, and non-scheduled or whole person impairment benefits. Each type of benefit is calculated differently.

SCHEDULED IMPAIRMENT

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

A listing of the Maximum Benefit Rates is available under the *Desk Aids* section of the Division website.

To calculate benefits for scheduled impairment:

- Utilize the impairment rating assigned by the physician to the specific body part. Locate the number of weeks on the schedule for complete loss of use of that body part.
- Determine the scheduled rate of reimbursement in effect on the date of injury.

Number of weeks specified on the schedule for the body part x Impairment Rating x Statutory Rate = PPD award (scheduled)

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). To calculate permanent medical impairment benefits for non-scheduled injuries:

- Utilize the nonscheduled or whole person impairment rating assigned by the physician.
- Calculate the claimant's age on the date of MMI to determine what age factor applies. (The Age Factor Chart is available under the Desk Aids section of the Division website.)
 - Utilize the TTD rate.

Medical Impairment Rating x Age Factor x 400 weeks x TTD rate =PPD award (nonscheduled)

TIPS

- 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 (whole person). *See* C.R.S. §8-42-107(7)(b).
- Keep in mind—there is a maximum cap on benefits based on the date of injury. The cap may change each year, effective July 1st.

MENTAL IMPAIRMENT

Mental Impairment Benefits are calculated and paid in the same way as nonscheduled impairment, with the distinction that mental impairment benefits are limited to 12 weeks of payments. Temporary disability benefits which have been paid as a result of a mental injury (as opposed to being paid because of a physical injury) may be deducted from the 12 weeks of benefits.

TIPS

The 12-week payment limitation for mental impairment benefits does not apply to a victim of a crime of violence, nor to a victim of a physical injury or occupational disease that causes neurological brain damage. *See* C.R.S. § 8-41-301(2)(b).

Mental Impairment cannot be combined with other impairments for calculating the amount of permanent medical impairment; however, for injuries occurring on and after 7/1/2009, the percentage of mental impairment can be combined with other impairments for purposes of determining the cap. *See* C.R.S. § 8-42-107(7)(b)(III).

PERMANENT IMPAIRMENT BENEFITS FOR MINORS

- Scheduled Impairment – Minors

All scheduled injuries for minors are treated the same as adults.

**Number of weeks specified on the schedule for the
body part x Impairment Rating x Statutory Rate =
PPD award (scheduled)**

- 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).

It is important to remember that 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.

**Medical impairment rating x Age Factor x 400 weeks
x Maximum TTD rate at the time of MMI = PPD
award (nonscheduled for a minor)**

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

STATUTORY OFFSETS

Offsets prevent a duplication of 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.

For injuries occurring on or after May 29, 1991, benefits are reduced by 50% of federal survivor's benefits (Social Security death 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. *See Hoffman v. Hoffman, 872 P. 2d 1367. (Colo. App. 1994).*

DISABILITY BENEFIT OFFSETS

Offsets for disability payments may be taken against TTD, TPD, PPD (specific to claims with dates of injury prior to July 1, 2010), 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 Offset

- Only the original Social Security award is used to calculate the offset.
- Social Security cost-of-living increases should not be included when determining the amount to be offset. 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 divided in half. This amount is then deducted from the claimant's weekly compensation payment.

$$\text{Initial monthly (SSDI award x 12) } \div \text{ 52 x 50\% = } \\ \text{Amount of offset per week} \\ \text{Weekly workers' compensation benefit - Amount of} \\ \text{offset = New weekly benefit rate}$$

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 workers' 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 C.R.S. 31-30.5-204 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. C.R.S. § 8-42-103(1)(IV).

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% (the employer contribution) and reduced to a weekly rate. This amount is then deducted from the claimant's weekly PTD benefit payment.

$$\begin{aligned} &\text{Initial monthly Social Security retirement} \\ &\text{benefit} \times 12(\text{months}) \div 52 (\text{weeks}) \text{ times } 50 \\ &\text{percent} = \text{Amount of offset per week} \\ &\text{Weekly PTD benefit} - \text{Amount of offset} = \\ &\text{Weekly Benefit Rate} \end{aligned}$$

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.

$$\begin{aligned} &\text{Employer's contribution during covered} \\ &\text{employment} \div \text{Total contribution during} \\ &\text{covered employment} = \text{Employer's} \\ &\text{percentage of contribution} \end{aligned}$$

**Employer's percentage of contribution x
Weekly Retirement Benefit = Amount of
offset per week**

**Weekly PTD Benefit - Amount of offset =
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 persons with disabilities 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

Workers' Compensation benefits received under the law of another state or federal government for the same injury may have an effect on Colorado benefits.

- Multiple states may have jurisdiction over a claim.
- Benefits may be paid concurrently in multiple states.

TIPS

Permanent partial disability benefits are no longer offsettable on claims with dates of injury on or after July 1, 2010.

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).

- 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.
- Determine the weekly offset amount by multiplying the original SSDI monthly award by 12, divide by 52, times 50 percent.
- Determine the number of weeks of the payout period by dividing the PPD award by the PPD payout rate.
- Deduct the SSDI weekly offset amount from the weekly PPD payout rate to determine the weekly benefit amount.
- Multiply the weekly benefit amount by the number of weeks of the payout period.

For dates of injury on or after 7/1/2010, SSDI offsets are not applicable for PPD awards. § 8-42-103(c)(I).

VII. PAYING INDEMNITY BENEFITS

TEMPORARY DISABILITY BENEFITS

Benefits are calculated based on a 7 day week.

The initial payment of temporary benefits must be paid immediately upon the filing of an admission for benefits. *See* C.R.S. § 8-43-203(2)(b)(l).

Per Rule 5-6(B), benefits should be paid through the date the payment is actually issued, unless an admission terminating benefits in accordance with Rule 6 was filed at the time of payment. This will assist in avoiding disputes over whether payment is in arrears. Benefits must be paid at least once every two weeks from the date of the admission awarding benefits. *See* C.R.S. § 8-42-105(2)(a) and Rule 5-6(B).

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 admission and through the date of the check unless benefits were terminated pursuant to Rule 6. Continuing benefits must be paid at least once every two weeks thereafter from the date of the admission.

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 bi-weekly payment is due or payment must continue. *See* Rule 6 discussion in Section V. Rule 5-5(C).

Reaching the indemnity caps does not trigger the condition allowing termination of temporary benefits.

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. 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 website.

Scheduled injuries are paid at the compensation rate in effect for dates of injury during occurring on each July 1st of that year through June 30 of the following year.

Non-scheduled injuries are paid at the TTD rate, but not less than \$150 per week and not more than 50% of the state AWW in effect on the date of injury. Where scheduled and non-scheduled injuries have both occurred, they shall be paid concurrently. Rule 5-7(C).

DISFIGUREMENT BENEFITS

- In order to be eligible to receive disfigurement benefits, there must be permanent scarring or disfigurement to a body part normally exposed to public view.
- Permanent disfigurement can be awarded if a scar or disfigurement exists at least six months after the date of injury or last surgery.
- Public view is considered to be a scar or disfigurement that is visible when an individual is wearing a swimsuit.
- The maximum disfigurement benefits change every year based on the state's AWW. Consult the Division's website to determine the maximum in effect on the date of injury. In cases involving extensive disfigurement, there is a different, higher limit.

Determination of the Amount of 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 a Prehearing Administrative Law Judge or schedule an in-person hearing with the Office of Administrative Courts for determination of disfigurement benefits.

A Request for Disfigurement Award [by] Photo may be obtained from the Division website at www.colorado.gov/cdle/dwc and is filed with the Prehearing Conference Unit.

VIII. MEDICAL PAYMENTS

Medical Billing Utilization Standards

Payment of Medical Benefits

Providers must submit their bills for services rendered within 120 days of the date of service or the bill may be denied unless extenuating circumstances exist. Extenuating circumstances may include, but are not limited to, delays in compensability being decided or instances when the provider has not been informed where to send the bill. *See* Rule 16-7.

For every medical service bill submitted by a provider, the payer must reply with a written notice or explanation of benefits (EOB) within 30 days of receipt of the bill. For a list of EOP requirements, see Rule 16-11(A). Adjustment codes must be clear (i.e., state you need the operative report). A specific person who has knowledge of the bill and can discuss disputes must be listed on the EOB with a contact phone number.

Medical Billing Disputes

If the Division receives a Medical Billing Dispute Resolution request from a provider, the payer may be sent a Request for Written Response (Form WC182). Per Rule 16-11(E), the payer has ten (10) business days to respond in writing to this request.

Prior Authorization

Prior authorization for a prescribed service or procedure may be granted immediately and without medical review; however, the payer must respond to all providers requesting prior authorization within seven (7) business days from receipt of the provider's completed request, as defined in Rule 16-9(F). Failure of the payer to timely comply will result in authorization for payment. *See* Rule 16-10 for guidelines on contesting a prior authorization request.

Rule 16-3 requires use of the Medical Treatment Guidelines in Rule 17 and prohibits the payer from

dictating the type or duration of medical treatment, or from imposing his or her own internal guidelines or other standards for medical care determination.

Medical Fee Schedule

The maximum allowance for all providers is 100% of the unit value times the appropriate conversion factor as defined in Rule 18-4. The workers' compensation fee schedule is reviewed and updated annually and is supplemented with the Director's Interpretive Bulletin 13 (Fee Schedule Related Issues) for the applicable year.

If a payer takes a Preferred Provider Organization (PPO) discount, be prepared to provide the billing party a copy of the contract, upon request, within 30 days. See Rule 16-11(A)(4).

Use of agents, including but not limited to Preferred Provider Organization networks, bill review companies, third party administrators (TPAs), and case management companies, shall not relieve the employer or insurer from their legal responsibilities for compliance with these Rules. See Rule 16-6(A).

IX. Medical Treatment Guidelines

Rule 17 provides a system of evaluation and treatment guidelines for high cost or high frequency categories of occupational injury or disease to assure appropriate medical care at a reasonable cost. There are nine sets of guidelines as Exhibits to Rule 17 that include the following:

- Low Back Pain
- Thoracic Outlet Syndrome
- Shoulder Injury
- Cumulative Trauma Conditions
- Lower Extremity
- Complex Regional Pain Syndrome (CRPS) / Reflex Sympathetic Dystrophy
- Cervical Spine Injury
- Chronic Pain Disorder
- Traumatic Brain Injury

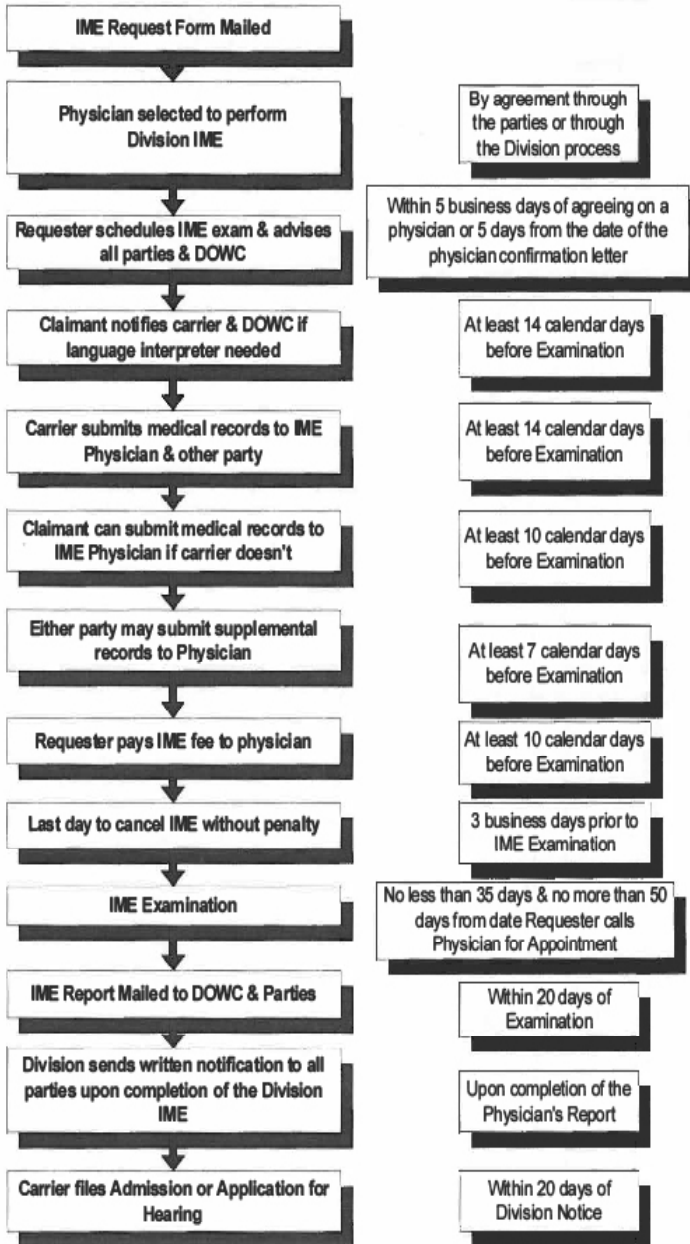
Both insurers and health care providers must use the medical treatment guidelines to prepare or review treatment plans for injured workers. *See* Rule 16-3. In particular, insurers must routinely and regularly review claims to ensure that medical care is consistent with these guidelines. *See* Rule 17-2(B). Insurers may not dictate medical treatment by relying on their own internal guidelines or other standards. *See* Rule 16-3.

Adjusters are urged to review the General Guidelines Principles described in the guidelines. As a claims adjuster, we recognize that you are often the first point of contact for providers requesting an intervention that lies outside of the guidelines. The question you should first consider when presented with a provider's request is: "has the treatment been shown for this patient to improve function, such as return-to-work, or activities of daily living?" Keep in mind two of the Division's Guidelines Principles: Positive Patient Response, and Surgical Interventions.

The Division recognizes that deviations from the guidelines may be appropriate in individual cases. When a proposed medical treatment falls outside the guidelines, health care providers must complete a prior authorization request and payers are required to

respond within seven (7) business days. *See* Rule 16-9(B) and (C). In addition, after an evidentiary hearing, the Director or an Administrative Law Judge may order treatment that is outside of the guidelines if the treatment is reasonable, necessary, and related to the work-related injury or disease in that case.

X. DIVISION INDEPENDENT MEDICAL EVALUATION PROCESS (DIME)



XI. LUMP SUM PAYMENTS & CALCULATION OF DISCOUNT

LUMP SUM PAYMENTS OF PERMANENT PARTIAL, PERMANENT TOTAL, AND DEPENDENTS' BENEFITS

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 sums.

Lump sum payment(s) may be requested for permanent partial disability benefits (PPD), permanent total disability (PTD) benefits, or dependents' benefits.

For all injuries, with the date of injury *prior* to January 1, 2014, the lump sum cap for PPD, PT claims, and fatal claims with only 1 dependent was raised to \$80,860.10 or \$161,734.15 for fatal claims with multiple dependents. These limits apply regardless of the date of the lump sum request.

For injuries occurring *on or after* January 1, 2014 and through June 30, 2015, the lump sum cap for PPD, PT claims, and fatal claims with only 1 dependent was raised to \$81,435.67, or \$162,869.28 for fatal claims with multiple dependents. Information for rates in effect July 1, 2015, and thereafter, may be obtained from the Division website at www.colorado.gov/cdle/dwc

Each July 1, the maximum benefit cap will change based on the percentage increase or decrease to the state average weekly wage. The total of all lump sums issued per claim may not exceed the maximum in effect on the date the lump sum is requested. Once a lump sum is requested, the maximum aggregate lump sum amount is fixed as of the date the first lump sum over \$10,000 is requested.

Up to \$10,000 in permanent partial disability benefits shall be paid to the claimant upon written request to the carrier, less the discount of approximately 4% per annum. An agreement to the rating is not a prerequisite for payment of the lump sum. See Calculating Lump Sums of \$10,000 or less under the *Desk Aids* section of

the Division website.

Whenever a lump sum payment is requested, the lump sum will be discounted based on the present worth of partial payments, considering interest at 4% 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.

If the claimant is represented by counsel and the claimant has filed a *Request for Lump Sum Payment* (WC62), the carrier is required to issue payment, complete and file the required benefit payment information (either page 2 or page 3 of the form), with the Division, the claimant, and the claimant's attorney, within ten (10) business days. Page 2 of the form is specific to the calculation and proof of payment for permanent partial disability awards, while page 3 is to be completed and filed for permanent total and fatal lump sum payments.

If the claimant is not represented and has filed a *Request for Lump Sum Payment* (Form WC62), the carrier is required to provide lump sum calculation information to the Division and the claimant, (page 2 of the form), within ten (10) business days. The Director will then issue a Lump Sum Order. The carrier must issue payment within ten (10) business days of the mailing date of the Order.

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.

A lump sum may be issued based on a Final Admission that is disputed on an issue other than the PPD award. However, the claimant must agree to the admitted impairment award (for any lump sum in excess of the

automatic \$10,000), in order to be granted a lump sum. The Request for Lump Sum Payment form contains language stating that the claimant agrees to the permanent partial disability benefits awarded.

When the claimant asserts a claim for permanent total disability, a *Request for Lump Sum Payment* on benefits awarded in the Final Admission will be considered. See Rule 5-10.

TIPS

The Benefit Calculator on the Division website may be utilized to calculate lump sums, benefit rates, pay periods, present value, offsets, etc. It can be found under the *Insurers* section on the Division website at www.colorado.gov/cdle/dwc.

XII. CLOSING A CLAIM

BY FINAL ADMISSION

A claim is automatically closed 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 Rule 7-2.

A represented claimant is allowed to submit documents for approval by electronic mail.

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 Motion to Close may be filed with the Director. See Rule 7-1(B). Forms can be found on the Division's website.

After receipt of a Motion to Close pursuant to Rule 7-1(B)(2), the Director will issue an Order to Show Cause on why the claim should not be closed. If there is no response from the claimant within the designated time, the claim may be closed.

THE SURVEY

Insurers are required to conduct an exit survey of injured workers, or if deceased, the decedent's dependents upon closure of a claim. The results of the survey must be reported to the Division annually. *This applies to all claims that close on or after July 1, 2010.* The survey is currently available on the website.

XIII. SETTLEMENTS

All or part of any claim may be settled by the parties. If a settlement resolves all of the issues in a claim, it is considered “full and final.” Such a settlement must be approved by the Director or an Administrative Law Judge (ALJ) before it becomes effective and may only be reopened if a party can prove the existence of fraud or a mutual mistake of material fact.

All settlements must use one of the two the Uniform Settlement Agreement forms provided by the division. One form may be used when the claimant is represented (WC104); the other should be used when the claimant is *pro se* (WC 103).

Regardless of which form is being used, the parties are only permitted to alter specific sections of the form. If any other changes are made, the settlement will be rejected. The sections which may be altered are:

- Paragraph 2: The parties should include the consideration being offered settlement. This will include anything the claimant is receiving in exchange for settling the claim.
- Paragraph 9A: The parties may include any other terms which are specific to the agreement **AND** which fall under the Workers’ Compensation Act.
- Paragraph 9B: The parties may use this section to list agreements which do not fall under the Workers’ Compensation Act (such as Medicare Set Asides, waivers of claims and resignation agreements). If such agreements are included, they should be attached to the settlement and listed under this paragraph.
 - If the claimant is not represented by an attorney, the only attachment permitted under 9B is a Medicare Set Aside agreement.
 - Attachments listed in 9B are neither reviewed nor approved in the settlement process. The Division of Workers’ Compensation does not have jurisdiction to enforce these agreements.

A settlement does not become final until it is approved by the Director or an ALJ. Once the parties have reached agreement and signed the settlement documents, a settlement routing sheet (WC 105) must be completed and attached. The settlement can be mailed, hand-delivered or e-mailed to the Division. Instructions for submission (including the e-mail address) are on the routing sheet.

The submitted settlement documents must also include a settlement order (WC 73) for represented claimants or WC 102 for claimants without attorneys). The party submitting the documents should fill in the WC Number(s) and the caption. Once the settlement is approved, the order will be returned to the party that submitted the documents, who will then be required to serve the order on the other parties.

TIPS

- Only one copy of the settlement agreement needs to be submitted. The Division will keep the filed copy, so all parties should keep a copy of the agreement for their own records.
- The claimant's signature must be notarized and the information in the notary block (including the county where the notarization occurred) must be completed accurately by the individual notarizing the document.
- If the claimant is unrepresented, the settlement may only be approved after a Pro Se Advisement has occurred. Once the settlement documents have been submitted to the Division, either the adjuster or the respondent's attorney needs to contact the prehearing unit to schedule the advisement.
- The settlement documents may be completed by any party. It is not necessary to have an attorney complete the forms. An adjuster may sign the agreement on behalf of the insurer.
- For any settlement greater than \$75,000.00, the employer must receive written notice.

If the parties cannot reach agreement on a settlement, they may choose to attend a settlement conference with a Prehearing ALJ. These conferences are entirely voluntary and both sides must agree to attend.

XIV. REOPENING A CLAIM

Either the claimant or the carrier may file a Petition to Reopen. Complete Division form WC37 and send a copy to all 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. The claimant may apply for a hearing at any time. The filing of a Petition is voluntary and not required prior to a hearing on the issue of reopening. *See* Rule 7-3.

CARRIER'S PETITION TO REOPEN

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).

XV. 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 *Employer's 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.
- 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.
- 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 per one of the subsections, all components of that subsection must be satisfied and sent with the admission.
- If terminating benefits based on a supplemental report, verify it is properly signed by either the claimant or the employer, or both. Do not alter the format or the form.
- Verify that the time period admitted corresponds to the time period listed on the supplemental report, and that the date of the form is later than the return to work date.
- Do not omit or reduce the TTD rate once admitted without petitioning per Rule 6-4 or documenting the basis for an offset.
- Send written documentation of the TPD rates and periods. Use a TPD worksheet to document the TPD benefits admitted and paid. Vacation and/or sick leave are not included in TPD calculations. Vacation and/or sick leave earned

- by the employee cannot be used to replace or reduce disability benefits otherwise owed.
- Double-check the calculation of PPD benefits and list the PPD calculations on the admission.
 - Scheduled: Check the body part code for accuracy.
 - Non-scheduled: Double-check the age at MMI. Verify that the correct age factor is used.
 - PPD begins on the date that MMI is reached for all injuries.
 - If the claimant was a minor at the time of 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.
 - Attach the medical report used as the basis for MMI and PPD to all admissions. Verify this is completed or signed by ATP.
 - Apply the appropriate cap for the Date of Injury. (Note: Check online for the current cap. Caps may change every July 1.) TTD is due through the date of MMI regardless of the applicable cap unless termination is supported by Rule 6.

TIPS

Subsequent admissions:

- Always enter current certificate of mailing date when filing an amended/new admission
- Always include supporting documents when filing amended admissions.
- When filing amended Final Admissions, all relevant documents must be re-submitted with the current certificate of mailing date.
- Remarks section: utilize this section to explain your filing to all parties.
- Benefits that have been admitted and paid may not be withdrawn without an Order or stipulated agreement between all parties.

The Benefit Calculator on the Division website can be utilized to confirm that the correct amount of TTD was admitted and paid when filing admissions for closed periods of time. See www.colorado.gov/cdle/dwc.

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 on whether proper documentation had already been sent. See C.R.S. § 8-43-218(3).

XVI. ACRONYMS

AMA	American Medical Association
ALJ	Administrative Law Judge with OAC
ATP	Authorized Treating Physician
AWW	Average Weekly Wage
CATY	Claimant Attorney
CDLE	Colorado Department of Labor & Employment
CLMT	Claimant / Injured Worker
CLIME	Claimant's IME
COLA	Cost of Living Adjustment
CRS	Colorado Revised Statutes
DC	Chiropractor
DIME	Division Independent Medical Examination
DMP	Designated Medical Provider
DOB	Date of Birth
DOI	Date of Injury
DR	Doctor
DOWC	Division of Workers' Compensation
EOA	Entry of Appearance by an Attorney
EOB	Explanation of Benefits
EDI	Electronic Data Interchange
F&F	Full and Final Settlement
FA	Final Admission of Liability
FFA	Fatal Final Admission
FGA	Fatal General Admission
FEIN	Federal Employer Identification Number
FMC	Future Medical Care
FO	Final Order
FROI	First Report of Injury
ICAO	Industrial Claim Appeals Office
ICAP	Industrial Claim Appeals Panel
IME	Independent Medical Examination
IW	Injured Worker
LE	Lower Extremity
LS	Lump Sum
MD	Medical Doctor
MED	Medical / Medical Report / Medical Records
MMI	Maximum Medical Improvement
MMIF	Major Medical Insurance Fund
MO	Medical Only Claim
MOD	Modified Duty
MTC	Motion to Close

NCCI	National Council on Compensation Insurance
N&P	Notice and Proposal
NOC	Notice of Contest
NP	Nurse Practitioner
OAC	Office of Administrative Courts
OBJ	Objection
ORD	Order
PA / PA-C	Physician's Assistant
PALJ	Prehearing Administrative Law Judge (DOWC Prehearing unit)
PERA	Public Employees' Retirement Association
PET	Petition
PH / PHC	Prehearing Conference
PHO	Prehearing Order
PPD	Permanent Partial Disability
PPO	Preferred Provider Organization
PT	Physical Therapy
PTD	Permanent Total Disability
RATY	Respondent Attorney
RIME	Respondent's IME
R/O	Reopen
RCVD	Received
RE:	Regarding
REQ/RQST	Request
RESP	Response
ROGS	Interrogatories
RRTW	Release to Return to Work
RTRN	Return(ed)
RTW	Return to Work
SCHED	Schedule(d) Rating
SCO	Show Cause Order
SIF	Subsequent Injury Fund
SROI	Subsequent / Supplemental Report of Injury
SSDI	Social Security Disability Income
SSI	Social Security Income
SSN	Social Security Number
SROI/delete	Subsequent Report of Injury (EDI term)
STC	Settlement Conference
STIP	Stipulated / Stipulation Agreement
STLMT	Settlement
SUPP/SUPL	Supplemental (Report)
SX/SURG	Surgery
TERM	Termination
TPA	Third Party Administrator

TPD	Temporary Partial Disability
TTD	Temporary Total Disability
UE	Upper Extremity
UI	Unemployment Insurance
UR	Utilization Review
WC	Workers' Compensation
WCC	Worker's Claim for Compensation
WC#	Division-assigned Workers' Compensation Number
WP	Waiting Period
WU/WP	Working Unit / Whole Person

XVII. DESK AIDS

The following Desk Aids are available in their entirety on the Division website at www.colorado.gov/cdle/dwc and can be viewed, printed, and downloaded in Word or Adobe Acrobat.

- 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
- Motion to Close/Show Cause Order

XVIII. 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 website at www.colorado.gov/cdle/dwc or can be requested by calling Customer Service.

- 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
- Workers' Compensation Insurance Requirements for Employers

XIX. PHONE NUMBERS

DIVISION OF WORKERS' COMPENSATION

633 17th Street, Suite 400
Denver, CO 80202
www.colorado.gov/cdle/dwc

Customer Service: 303-318-8700 / 1-888-390-7936 (toll-free)

Special Funds:
Major Medical, Subsequent Injury, and Medical Disaster Funds:
1-800-453-9156

Prehearing Conferences: 303-318-8736

OTHER GOVERNMENT OFFICES

Office of Administrative Courts	303-866-2000
Division of Insurance	303-894-7499
Mine Safety and Health Administration	202-693-9400

Occupational Safety and Health Administration	
Denver area	303-844-5285
All other employers	303-843-4500

Unemployment Insurance Tax	
Denver area	303-318-9100 / 303-318-9055
In state toll-free number	1-800-480-8299

NOTES

COLORADO DEPARTMENT OF LABOR & EMPLOYMENT
Division of Workers' Compensation
633 17th Street, Suite 400
Denver, CO 80202-3626

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