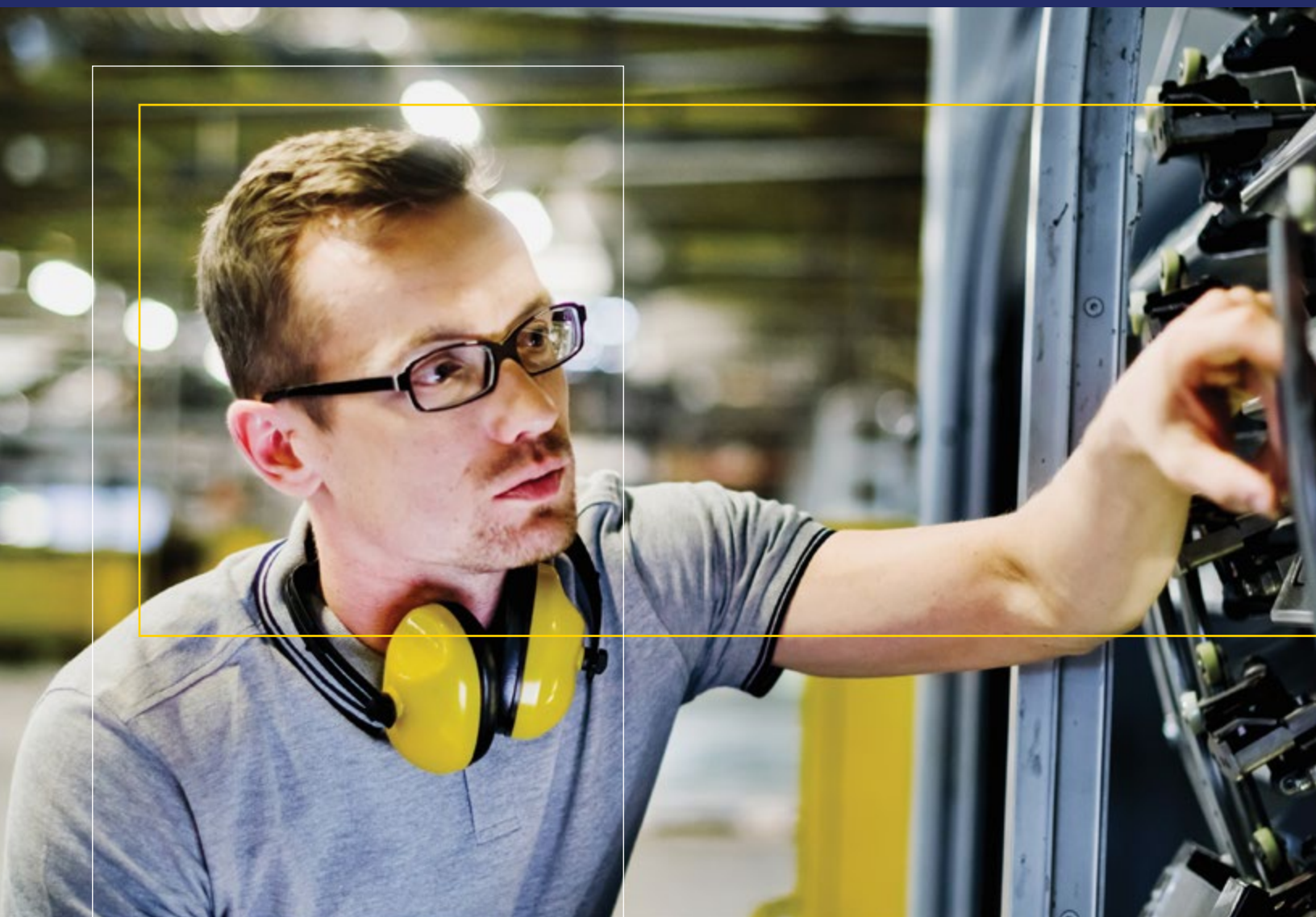
COLORADO
Department of
Labor and Employment
Division of Workers' Compensation

Guide to
Adjusting Workers' Compensation Claims



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Disclaimer

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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What's What in Workers' Compensation

FORMS

First Report of Injury (FROI) (WC 1)

This report is filed with the Division of Workers' Compensation (Division), if certain conditions are met, within 10 days of knowledge or notice to the employer of a work-related injury or occupational disease. The FROI may only be filed by the employer or carrier. See page 9 for a discussion of the necessary conditions.

General Admission (GA) (WC 2)

This form is used by the carrier to admit responsibility for a workers' compensation claim. It provides information on the types of benefits being paid.

Final Admission (FA) (WC 4)

This form is filed by the carrier as the final statement of the amount of benefits to be paid to the claimant. If the claimant does not object within 30 days, the admission becomes final, and the claim is closed.

Worker's Claim for Compensation (WCC) (WC 15)

This form is filed by claimants and provides notice to the Division and the carrier that workers' compensation benefits are requested.

Dependent's Notice and Claim for Compensation (Dependent's Notice) (WC 18)

This form is filed by the dependents of a deceased worker and provides notice to the Division and the carrier that workers' compensation dependent benefits are claimed.

Notice of Contest (NOC) (WC 74)

This form is filed by the carrier to deny liability for a workers' compensation claim.

FILING COMPONENTS

Block Number

The four-digit number issued by the Division to licensed self-insured employers and insurance carriers. The block number must be included on all filings made with the Division.

Third-Party Administrator (TPA) Codes

The two-letter adjusting code assigned to TPAs. This code must be included on all filings made with the Division by a TPA. If a carrier uses a TPA with multiple office locations, they must include the proper adjusting code for each location to ensure mail is directed to the appropriate office. A TPA may be designated on an FROI, an NOC or an admission. The Division will not send correspondence to the TPA until the designation is made.

Workers' Compensation Number (WC#)

This number is assigned by the Division to help identify a claim in the Division's system. The WC# for a claim transmitted via EDI is assigned and submitted to the carrier electronically. Check internal company procedures on how to obtain the assigned WC#.

MEDICAL CONSIDERATIONS

Authorized Treating Physician (ATP)

The physician selected by the claimant from the designated provider list or any other physician to which the claimant is properly referred.

Division Independent Medical Examination (DIME)

A DIME is required if there is a dispute regarding the Maximum Medical Improvement (MMI) date or whole person impairment rating and the parties wish to bring this dispute before a judge.

Impairment Rating

A percentage that represents the amount of loss of the injured body parts, which is based on guidelines published by the American Medical Association (AMA) 3rd Edition.

Maximum Medical Improvement (MMI)

The point at which the claimant has stabilized in their recovery and no further reasonable or necessary treatment is expected to improve their condition.

Maintenance Care

The ATP may recommend post-MMI maintenance medical care to maintain the worker's current functional status and MMI.

Notice to Treat

This process applies to treatment consistent with the Medical Treatment Guidelines and has an established value under Rule 18: Medical Fee Schedule.

Prior Authorization

This process applies to prescribed treatment that exceeds the recommended limitations set forth in the Medical Treatment Guidelines, is unpriced or otherwise required by rule.

Links and Resources

- Division homepage: cdle.colorado.gov/dwc
- Statute, Rules and Guidance: cdle.colorado.gov/statute-rules-guidance
- Forms: cdle.colorado.gov/forms
- Benefits Calculator: dowc.cdle.state.co.us/benefits
- Publications and Desk Aids: cdle.colorado.gov/publications-and-desk-aids
- Employer Guide: codwc.box.com/v/EmployerGuide
- Employer Guide in Spanish: codwc.box.com/v/EmployerGuide-Espanol
- Injured Worker Guide: codwc.box.com/v/InjuredWorkerGuide
- Injured Worker Guide in Spanish: codwc.box.com/v/InjuredWorkerGuide-Espanol

Forms and Filings

Please make sure to use the most current version of Division forms available at cdle.colorado.gov/forms.

The following forms should be emailed to **cdle_dowc_filings@state.co.us**:

- General Admission (GA) (WC 2)
- Final Admission (FA) (WC 4)
- Petition to Modify, Terminate or Suspend Compensation (WC 54)
- Request for Lump Sum Payment (WC 62)
- Motion to Close for Failure to Prosecute and Order to Show Cause (MTC) (WC 192)

The carrier should combine all exhibits and only include **one file per submission**. The file name should include the following elements in the following order: WC#, claimant's first and last name, the shorthand for the type of document (EOA, WCC, OBJ, COA, FA, GA, etc.). Please include the dashes (-) when typing the WC#. When naming files, please ensure you are separating the elements by spaces, not commas.

Example: 1-234-567 John Doe EOA

Establishing a Claim With the Division

FIRST REPORT OF INJURY

An FROI must be filed with the Division **within 10 days** of knowledge or notice to the employer that a work-related accident resulted in **any of the following**:

- Lost time in excess of 3 shifts or calendar days.
- Permanent impairment
- Exposure or contraction of an occupational disease as listed in rule.
- If any claim for benefits is denied, including a medical-only claim.
- The injured worker requires 180 or more days of medical treatment.

An FROI must be filed with the Division within 3 days of knowledge or notice that a work-related accident resulted in death or injury to three or more employees. When a filing is required, the carrier must electronically submit an FROI through the electronic data interchange (EDI). EDI may be accessed at cdle.colorado.gov/dwc/insurers.

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Filing a Position Statement

TIMING

A position statement must be filed with the Division within 20 days of the FROI being submitted. The carrier may use an NOC, a GA or an FA when filing a position statement. In the case of a WCC or Dependent's Notice, a position statement must be filed **within 20 days** of the Division mailing a copy of the claim to the carrier.

At the time an admission or denial is filed, the carrier **must also provide the claimant a Division of Workers' Compensation Claimant Brochure** along with any supporting documentation, the carrier claim number and appropriate adjuster contact information. The brochure is available at **cdle.colorado.gov/workers-compensation-publications**. Please contact the Claims Management Unit at **cdle_dowc_claims@state.co.us** with any questions about these requirements.

NOTICE OF CONTEST (NOC)

An NOC is filed to **deny liability** for a workers' compensation claim. **This form must be filed electronically via EDI**. An FROI is required prior to filing an NOC. The carrier cannot file an NOC on a previously admitted claim. If a denial was filed to complete an investigation, no additional filing is needed unless the carrier wishes to admit liability.

GENERAL ADMISSION (GA)

A GA is filed to **admit liability** for a workers' compensation claim. **This form must be filed via email to cdle_dowc_filings@state.co.us.** The GA accepts the claim as compensable and admits liability for reasonable and necessary medical expenses related to the injury and any potential lost wage benefits.

SUBSEQUENT ADMISSIONS

Subsequent admissions must be filed when there is a change in temporary benefits, including initiating, increasing, terminating or changing the type of benefits. Only benefits that are statutorily owed should be listed in the Benefits History section of the admission.

FINAL ADMISSION (FA)

An FA is filed at the conclusion of a workers' compensation claim to outline all benefits for which liability is admitted on the claim and establishing the carrier's position on permanent disability benefits and any post-MMI medical benefits. **This form must be filed via email to cdle_dowc_filings@state.co.us.** If the claimant does not object to the FA **within 30 days** from the date of the admission, then the issues addressed in the FA become final. Any overpayments of indemnity benefits should be documented in the FA's Remarks section and Amount Overpaid field.

Filing an FA Based on Medical Documents

An FA may be filed when the claimant reaches MMI. The narrative and permanent impairment worksheet(s), if applicable, must be attached and contain an opinion from the ATP about the date of MMI, permanent impairment and whether maintenance care is required to maintain MMI.

Filing an FA for Abandonment of a Claim

There are two ways that an FA may be filed based on abandonment. The claimant cannot be receiving temporary disability at the time of abandonment.

1. If the claimant has missed two consecutive medical appointments and failed to respond to the 30-day letter. The FA should include:
   - Documentation of two consecutive missed medical appointments.
   - A copy of the 30-day letter sent to the claimant and claimant's attorney, if applicable, after the second missed appointment, asking if further medical treatment is required and whether the claimant is claiming permanent impairment.
     - The **letter must state** in bold capital letters, "**FAILURE TO RESPOND TO THE LETTER WITHIN 30 DAYS WILL RESULT IN A FINAL ADMISSION BEING FILED**."
       - If the claimant responds to the letter within 30 days, the carrier cannot file an FA.
       - The letter **should not state**, "will result in closure of your claim."
     - If the claimant timely objects to the FA, the carrier must withdraw the FA by filing a GA.
2. The claimant may voluntarily abandon their claim by filing a Voluntary Abandonment of Claim (WC 191).
   - The form must be signed and dated by both the claimant and the carrier.

MAXIMUM MEDICAL IMPROVEMENT (MMI)

Within 30 days of the date of mailing or delivery of a medical report from the ATP stating the claimant has reached MMI, the carrier **must file one of the following**:

- An FA
- A Notice and Proposal and Application for a DIME (WC 77)
- An Application for Hearing with the Office of Administrative Courts (OAC)
  - If disputing a scheduled impairment rating, or any other issues which would be admitted on the FA.

Failure to request a DIME waives the right to contest whole person impairment ratings and the MMI date. **If the DIME request or Application for Hearing is not filed within 30 days, the carrier must admit for the rating provided**. A DIME is not required to contest a scheduled impairment. Any disputes regarding the scheduled impairment can proceed straight to hearing; however, the carrier may initiate the DIME process if the carrier chooses to. The claimant may request a DIME if they feel they are not at MMI or should have a higher whole person impairment rating.

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Calculating Indemnity Benefits

AVERAGE WEEKLY WAGE (AWW)

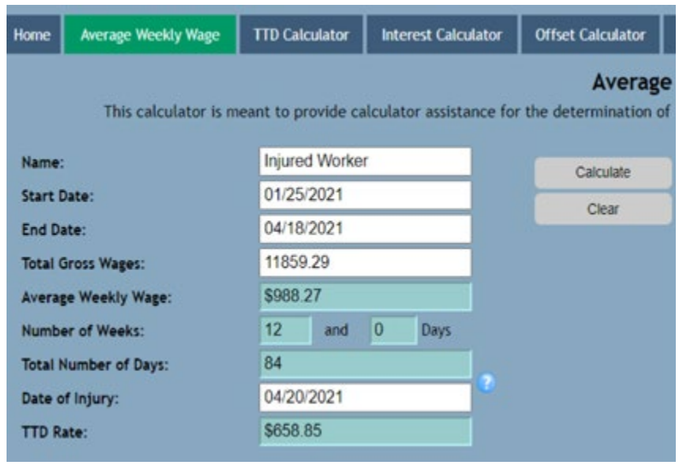
AWW is the average weekly amount the claimant was earning from **all jobs at the time of injury**.

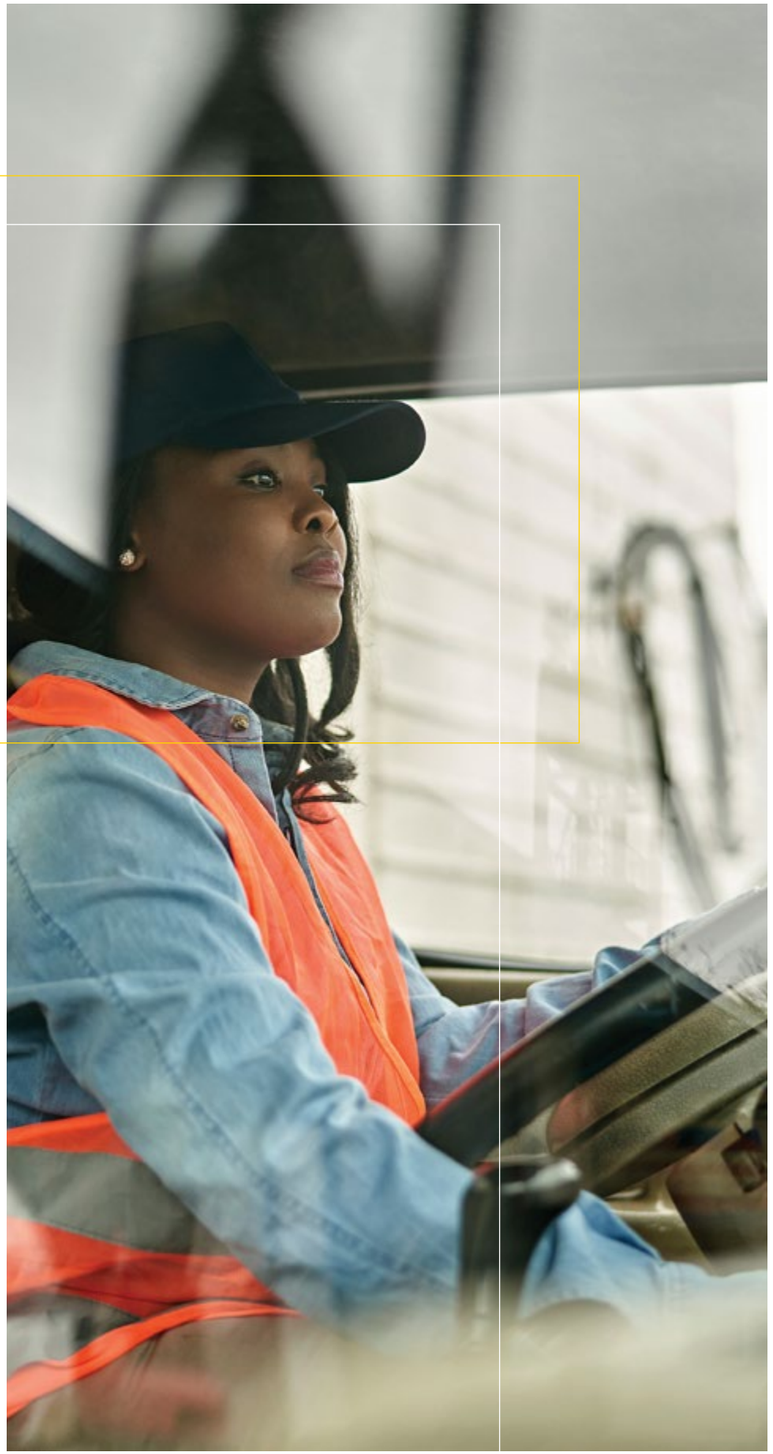
AWW is determined by adding all pre-tax gross wages earned by the claimant during a period of weeks and then dividing by that same number of weeks. Total gross wages include any wages reported to the IRS, including but not limited to regular wages, overtime, vacation, sick leave, tips, commissions, piecework, mileage and employer-provided board, rent or housing. If there are no wages because the claimant was injured close to their hire date, the AWW can be based on expected wages.

Example:
Claimant's date of injury (DOI) is 4/20/2021 and gross wages were received for the period 1/25/2021 through 4/18/2021 totaling $11,859.29.

Using the Benefits Calculator at **dowc.cdle.state.co.us/benefits**, *the AWW for that period of 12 weeks would be $988.27.*

As noted on the Benefits Calculator screen below, it is important to consider the date of hire (DOH) and DOI when calculating AWW. The wage date range must be after the DOH and prior to the DOI, even if the claimant earned wages after their date of injury.





If the AWW on the first indemnity admission is lower than the one stated on the FROI or WCC, documentation supporting the lower AWW must be attached to the first admission. Additional documentation is not required to increase the admitted AWW.

If the claimant loses their employer-paid health insurance benefits (medical, dental or vision), the admitted AWW must be increased by the full amount of the stated Consolidated Omnibus Budget Reconciliation Act (COBRA) letter on the date of benefit termination. A GA reflecting this change must be filed **within 15 days** of notice.

Example:

$$\left(\frac{\text{COBRA amount of \$600 per month} \otimes \text{12 months}}{\text{52 weeks}}\right) = \text{\$138.46 AWW increase}$$

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Paying Indemnity Benefits

TEMPORARY DISABILITY BENEFITS

There are two types of temporary disability benefits: Temporary Total Disability (TTD) and Temporary Partial Disability (TPD). Both types are calculated based on the AWW at the time of injury. All benefits are calculated and paid based on a 7 day week.

The initial payment of temporary benefits must be paid immediately upon the filing of an admission for benefits. Benefits must be paid at least once every 2 weeks from the date of the admission awarding benefits. If payment is sent through the U.S. mail, payment must be postmarked at least 3 business days prior to the due date. All other payment methods must be **received** by the claimant by their due date.

Temporary Total Disability (TTD)

TTD benefits are due when a claimant is unable to work as a result of the injury and has missed at least 3 days **or** 3 shifts of work. The waiting period of the first 3 missed days or shifts is not paid unless a claimant's period of disability lasts longer than 2 weeks from the day they left work.

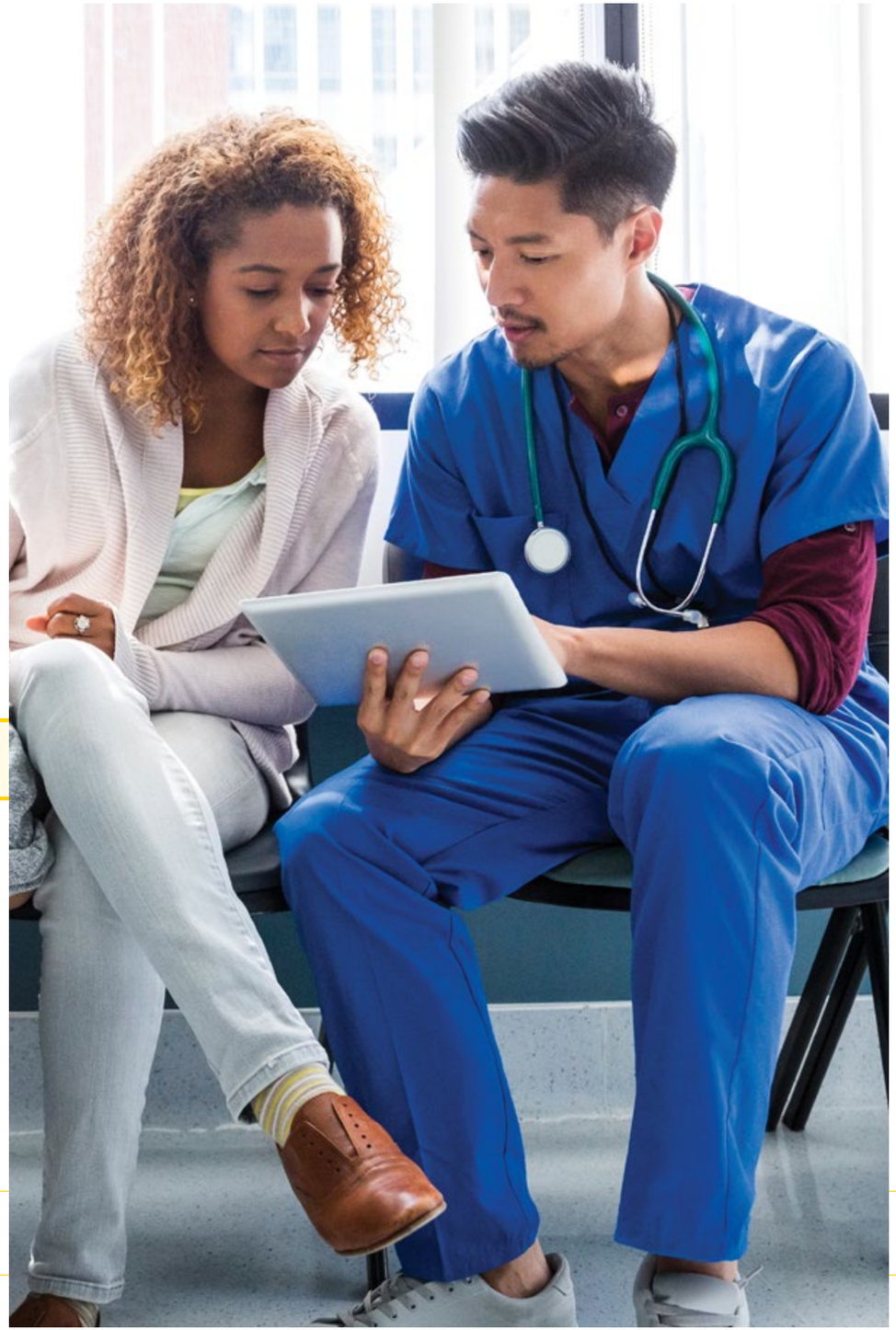
The TTD benefit rate is calculated at two-thirds of the claimant's AWW, up to the maximum TTD weekly rate in effect on the date of injury.

AWW ⊗ ⅔ = TTD

Example:
Claimant's gross earnings are $1,500 per week. Take this amount and multiply by two-thirds to get the TTD rate of $1,000.00. With higher wage earners, consider whether the maximum TTD rate for the date of injury applies.

$1,500 x ⅔ = $1,000.00

Visit the Division's Benefits Calculator at **dowc.cdle.state.co.us/benefits** for help with these calculations.



Temporary Partial Disability (TPD)

TPD benefits are due when a claimant returns to work at reduced wages and/or hours. The TPD rate should be calculated by subtracting the gross earnings from the AWW and multiplying the difference by two-thirds up to the maximum rate.

(AWW ⊖ Gross earned) ⊗ ⅔ = TPD

Example:
Claimant normally earns $1,500 per week working 40 hours, but the employer is only able to offer modified duty 20 hours per week.

($1,500 - $750.00) x ⅔ = $500

Visit the Division's TPD Benefit Worksheet at **cdle.colorado.gov/wc-desk-aids** for help with these calculations.

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Termination or Modification of Temporary Benefits

UNILATERAL TERMINATION OR MODIFICATION

When temporary disability benefits are terminated, or benefits are changed from TTD to TPD, an admission must be filed on or prior to the next scheduled date of payment. Supporting documentation must accompany the admission for unilateral termination or reduction of temporary benefits.

Attach documents to the admission that satisfy **one of** the following subsections of Rule 6:

- A report of MMI, impairment and need for continued medical maintenance from the ATP provided the carrier states a position on permanency consistent with the ATP's report.
- A medical release by the ATP to return to full/regular duty.
- A signed statement by the employer or employee of return to work at full wages and hours.
- A signed statement by the employer or employee of return to work at reduced hours and/or wages and admission for TPD benefits, if any.
- A copy of a written offer of modified employment delivered to the claimant with a signed certificate of service.
    - The offer must include duties, wages, hours **and** a statement from the ATP that the employment offered is within the claimant's physical restrictions.
    - A copy of the ATP's approval of duties which shows the claimant was copied on the initial request.
    - The claimant is allowed 3 business days to return to work in response to an offer of modified duty.
- A copy of a certified letter or a letter with a signed certificate of service advising that temporary disability benefits will be suspended for failure to appear at a rescheduled medical appointment with the ATP and a statement from the ATP documenting the claimant's failure to appear.
- Death certificate or letter and a statement of position on liability for death benefits.

Petition to Suspend, Modify or Terminate Temporary Benefits (WC 54)

A Petition to Suspend, Modify or Terminate Temporary Benefits may be filed if the carrier cannot suspend, modify or terminate temporary benefits under the unilateral provisions listed above. If the petition is filed **within 30 days** of the initial indemnity admission, the change can be retroactive.

PERMANENT IMPAIRMENT BENEFITS

Benefits for permanent impairment (PPD) are due **on the date of the admission and every 2 weeks thereafter until paid in full**. If payment is sent through the U.S. mail, payment must be postmarked at least 3 business days prior to the due date. All other payment methods must be **received** by the claimant by their due date. Benefits for PPD should start on the date of MMI.

There is a statutory maximum cap on PPD benefits based on the date of injury and the whole person impairment rating. To determine which statutory maximum to use, combine the whole person ratings for all affected body parts, including mental ratings. Injuries on the schedule will be converted to the whole person by the doctor. For payment, injuries are paid as detailed below. Visit the Division's Benefits Calculator at **dowc.cdle.state.co.us/benefits** for help with these calculations.

Scheduled Impairment

Scheduled impairment refers to body parts such as specific extremities (legs/arms) or digits (fingers/toes) and can also include blindness to one eye, hearing loss or the loss of a tooth. These benefits are paid at the scheduled rate based on the date of injury. The scheduled rate changes yearly on July 1.

To calculate benefits for scheduled impairment you will need:

- The impairment rating percentage assigned by the physician.
- The number of weeks listed on the **Scheduled Impairment Chart**.
- The scheduled impairment weekly rate on the date of injury.

% of impairment
⊗
Scheduled Impairment Chart weeks
⊗
Scheduled impairment weekly rate
=
Scheduled PPD Award

Example:
Claimant injured their shoulder and received an upper extremity impairment rating of 12%. Check the scheduled impairment weekly rate for the date of injury. If the claimant was injured on 8/23/2020, use the scheduled impairment weekly rate of $337.11. Refer to the PPD benefits for scheduled injuries. A shoulder injury would be considered arm at shoulder, or body code 01, which is 208 weeks. Therefore, the calculation would be:

12% x 208 x $337.11 = $8,414.27

The statutory rate and number of weeks can be found in the Division's Quick Reference Guide at **cdle.colorado.gov/wc-desk-aids**.

Whole Person (Non-Scheduled) Impairment

The whole person (WP) impairment calculation is used when an injury results in permanent medical impairment not set forth in the scheduled impairment chart.

To calculate permanent medical impairment benefits for whole person injuries, you will need:

- Impairment rating percentage assigned by the physician.
- Age factor based on age at MMI.
  - The Age Factor Chart can be found in the Division's Quick Reference Guide at **cdle.colorado.gov/wc-desk-aids**.
- 400 weeks
  - This amount is used in all whole person impairment calculations.
- TTD rate
  - Utilize the TTD rate prior to any offsets.
  - Rate may not be less than $150 per week or more than the maximum PPD weekly rate in effect on the date of injury.

% of impairment ⊗ Age Factor ⊗ 400 weeks

⊗ TTD Rate = WP PPD Award

Example:
Claimant is placed at MMI on 8/20/2021 and receives 15% whole person impairment rating for a low back injury that occurred on 7/3/2018. Claimant has an AWW wage of $1,000 and a TTD rate of $666.67 (1,000 x ⅔). The claimant's date of birth is 2/6/1964, making them 57 years old on the date of MMI. Based on the claimant's age of 57, the age factor would be 1.06. Therefore the rating calculation would be:

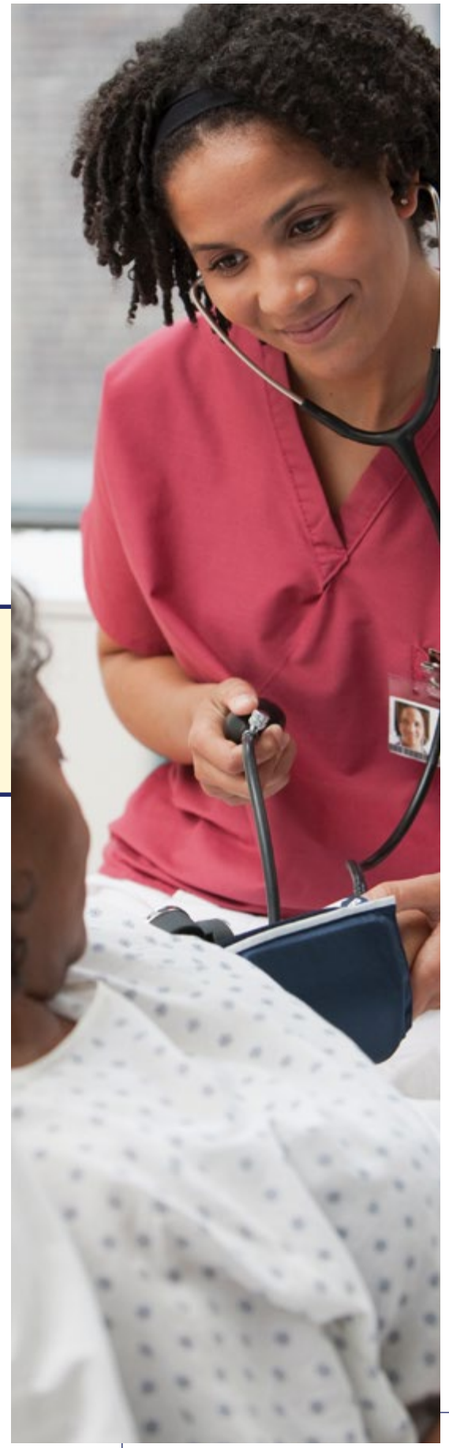
15% x 1.06 x 400 weeks x $666.67 = $42,400.21

If the claimant's AWW was $1,500 and TTD rate was $1,000, then consider the maximum TTD weekly rate for the date of injury of 7/3/2018, which is $987.84. Therefore, the calculation would be:

15% x 1.06 x 400 x $987.84 = $62,826.62

In both scenarios, the maximum PPD weekly pay out rate would be $542.78. This is the amount that the PPD award would be paid out at, which should not to be confused with the calculation of the amount owed.

The maximum whole person PPD payout rate can be found on the Division's Quick Reference Guide at **cdle.colorado.gov/wc-desk-aids**.



Minors

For minors, a whole person PPD award is calculated using the maximum TTD rate in effect at the time of MMI. A claimant is a minor if they were **under the age of 21 on the date of injury**. This remains true even if they are over 21 at MMI.

% of impairment ⊗ Age Factor ⊗ 400 weeks

⊗ Maximum TTD Rate at the time of MMI

= Minor WP PPD Award

Example:
Claimant injures their back on 1/15/21 and is placed at MMI on 6/30/2021. Their date of birth is 4/2/2001 which makes them 19 years old on the date of injury and 20 years old on the date of MMI. They were awarded a 10% whole person permanent impairment. The PPD calculation will always be at the maximum TTD weekly rate for the date of MMI, regardless of what their actual TTD rate is.

10% x 1.80 x 400 x $1,022.56 = $73,624.32

The Division's Benefits Calculator is available at **dowc.cdle.state.co.us/benefits** and based on the date of birth entered helps identify minor claimants and adjusts the TTD rate to be used automatically.

Mental Impairment

Mental impairment benefits are typically limited to 36 weeks. If temporary disability benefits were paid as a result of a mental injury rather than a physical injury, those benefits are deducted from the overall weeks allowed. If the claimant was a victim of a crime of violence, then there is no limit. Mental impairment benefits are calculated and paid the same as a whole person impairment.

Offsets

Unilateral

Offsets may be taken unilaterally for disability, retirement, unemployment and workers' compensation benefits received from another state or the federal government. **Offsets may not reduce benefits below zero**.

1. Social Security Disability (SSDI) offsets may be taken against TTD, TPD and PTD benefit at a reduction equal to 50% of the original award. Attorney fees cannot be included in the reduction. For short and long-term disabilities, the offset amount is the percentage of the employer's contribution.
2. Retirement offsets may be taken against PTD benefits, but only if the claimant was at least 45 years old when they were injured. The offset amount for an employer-paid retirement plan is the percentage of the employer's contribution.
3. For unemployment benefits, 100% of the amount can be taken against TTD, TPD and PTD.
4. For benefits from other states, 100% of the amount can be taken against TTD, TPD, PPD and PTD for the same claim.

Safety Rule Violations and Intoxication

Injuries caused by intoxication, the willful failure to use a safety device, failure to follow a safety rule or misrepresentation on an application for employment may result in the claimant's compensation benefits being reduced by 50%, including PPD benefits. This offset must be asserted on the first indemnity admission with supporting documentation. **Reduction of medical benefits is not permitted**.

DISFIGUREMENT BENEFITS

Disfigurement benefits are paid to claimants with permanent scarring or disfigurement to a body part normally exposed to public view. Public view is considered any part of the body visible when an individual is wearing a swimsuit. Claimants may apply to the Division or the OAC for the determination of a disfigurement award. Alternatively, the parties may stipulate this figure.

FATAL BENEFITS

Establishing a Claim for Death Benefits With the Division

The carrier must file an FROI in the event of a fatal injury **within 3 days of notice**. The box on the FROI asking "Did injury cause death?" should be marked "yes," with the corresponding date of death. If there is an established workers' compensation claim, that claim will be closed with an FA, and a new FROI must be filed. The fatal claim will be assigned its own WC#.

Amount of Death Benefits

Benefits are calculated at two-thirds of the deceased employee's average weekly wage.

Types of Dependents

There are two kinds of dependents, whole and partial. Whole dependents include any spouse, including common law, children under the age of 18 and children under the age of 21 who are full-time students at an accredited school. Partial dependents are any individual who can show they were wholly or partially supported by the deceased at the time of death. If there are any whole dependents, there cannot be any partial dependents.

FATAL ADMISSION

Fatal Admissions are used in cases where a work-related injury resulted in death. A Fatal GA (WC 151) is filed to admit liability or update a change to dependents' benefits. A Fatal FA (WC 153) is filed if any of the following apply:

- The deceased worker leaves **no statutory dependents**, and payment is made to the Colorado Uninsured Employer Fund.
    - For fatalities involving a minor, please contact the Division at **cdle_dowc_claims@state.co.us**.
- All of the dependents' benefits have ended.

Adjusters with questions on a fatality claim are strongly encouraged to contact the Division's claims manager assigned to the claim.

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Medical Payments and DIMEs

UTILIZATION STANDARDS

Payment of Medical Benefits

Providers must submit their bills for services rendered **within 120 days** of the date of service. For every service bill submitted by a provider, the payer must reply with written notice or explanation of benefits (EOB) **within 30 days** of receipt of the bill.

Medical Treatment Guidelines

Rule 17 establishes Medical Treatment Guidelines. There are nine exhibits to Rule 17 that address occupational injuries that occur most frequently or incur high costs of treatment.

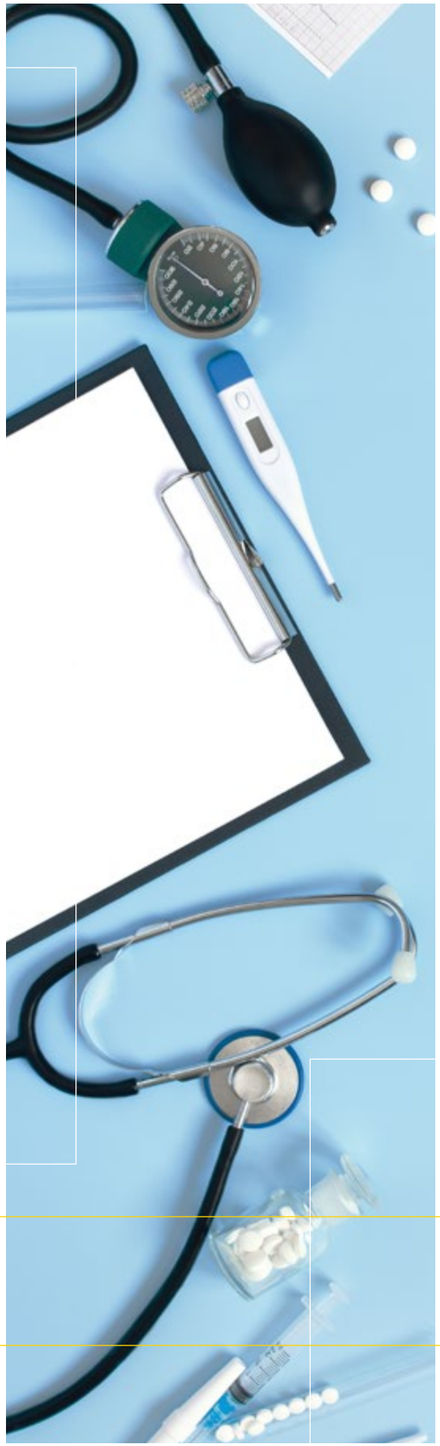
Rule 16 requires providers and payers to use the Medical Treatment Guidelines. It prohibits payers from dictating the type or duration of medical treatment, from redirecting referrals and from imposing their own internal guidelines or other standards for medical care determination.

Notification

The notification process is for treatment consistent with the Medical Treatment Guidelines that has an established value under Rule 18: Medical Fee Schedule. This may be done by phone or by utilizing form WC 195. Notifications are not subject to medical review, and **payers have 7 days to contest** the proposed treatment, which is limited to reasons set forth in Rule 16. Failure to timely respond can result in the payer being responsible for payment.

Prior Authorization

Prior authorization is for a prescribed service that exceeds the recommendations or limitations set forth in the Medical Treatment Guidelines or when a fee is not established in Rule 18: Medical Fee Schedule. Prior authorization must be responded to **within 10 days**. A payer may not deny for medical reasons or relatedness without a medical review by a Colorado licensed and accredited physician. Failure by the payer to timely respond to a request will result in automatic authorization for payment. See Rule 16 for guidelines on contesting a prior authorization request.



DIMEs

Any party seeking a DIME must file a Notice and Proposal and Application for a DIME (WC 77) **within 30 days** of the determination of MMI.

Within 30 days from requesting a DIME, the parties can negotiate the selection of a physician. If the parties cannot agree, the carrier must file a Notice of DIME Negotiations (WC 165) and a three-physician panel will be issued.

The requesting party has **7 days** from the issuance of the three-physician panel to strike one physician and notify the opposing party and the DIME Unit. **Within 7 days** from the notice of the strike, the opposing party may strike another physician and notify the requesting party and the DIME Unit. If the Division does not receive notice of the selected physician **within 14 days** of issuing the three-physician list, it will randomly select one name from the remaining physicians.

Within 14 days of receiving the DIME Physician Confirmation, the requesting party must pay the base cost to the DIME physician and schedule the DIME.

All medical records must be submitted to the Division **within 30 days** of the Notice and Proposal and Application for a DIME (WC 77). Parties will have an opportunity to review the medical packet and request changes before it is issued to the DIME physician.

The DIME exam must be scheduled **no earlier than 45 days or later than 75 days** after the requesting parties receive the DIME Physician Confirmation.

Within 20 days of the examination, the DIME physician must submit the original report with all attachments to the DIME Unit and all parties. After receiving the DIME Unit's Notice of Completion, the carrier must file an admission (GA or FA) pursuant to the DIME or request a hearing **within 20 days**.

Refer to Rule 11 for more detailed information on the DIME process, or email the DIME Unit at cdle_imeunit@state.co.us with questions.

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Additional Considerations

LUMP SUM PAYMENTS AND CALCULATION OF DISCOUNT

Lump sum payments may be requested for PPD, PTD or fatal benefits.

An initial, automatic, one-time $10,000 lump sum shall be paid to the claimant upon written request to the carrier, less the discount of 4% per annum. All lump sums requested by the claimant will be discounted at 4% per annum. The carrier can choose to pay a lump sum at any time without a discount. The total of all lump sums issued may not exceed the maximum in effect on the date the first lump sum over $10,000 is requested.

Requests for lump sums over $10,000 are made on the Request for Lump Sum Payment (WC 62). For represented claimants, the carrier has **10 days** to either object or complete the benefit payment information on the form and pay the amount requested.

For unrepresented claimants, the carrier has **10 days** to either provide the benefit payment information on the Request for Lump Sum Payment (WC 62) to the Division and claimant or to object to the lump sum request. The Director will then issue a Lump Sum Order. The carrier must issue payment **within 10 business days** of the mailing date of the order.

The Division's Benefits Calculator at **dowc.cdle.state.co.us/benefits** may be used to calculate lump sums, benefit rates, pay periods, present value, offsets and more.

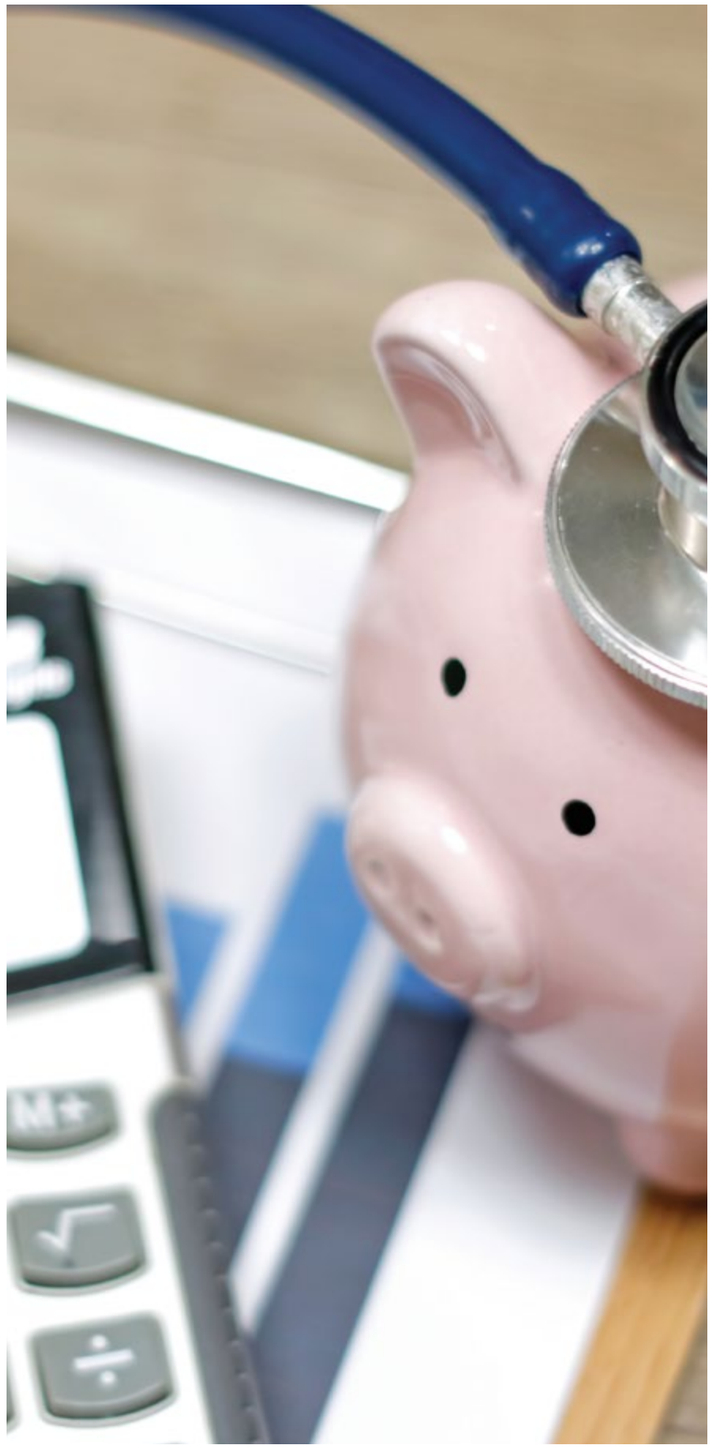
CLOSING A CLAIM BY RULE

When no action in furtherance of prosecution has occurred for at least 6 months, a Motion to Close for Failure to Prosecute (MTC) (WC 192) may be filed with the Director. After receipt of an MTC pursuant to Rule 7, 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.

Closure of a claim pursuant to Rule 7 **does not** terminate entitlement to any benefits which have been admitted by the employer, the insurer (such as medical benefits after maximum medical improvement) or benefits ordered by an Administrative Law Judge.

REQUIRED SURVEY

Carriers are required to conduct an exit survey of claimants, or if deceased, the deceased's dependents upon closure of a claim. Survey requirements are listed in Rule 5. The results of the survey must be reported to the Division annually and are available at **cdle.colorado.gov/dwc/insurers**.



SETTLEMENTS

The parties may settle all or part of any claim. All settlements must use the Claim Settlement Agreement (WC 104) provided by the Division. A settlement does not become final until the Director or an ALJ approves it. Once the settlement documents are signed and complete, the carrier should use the Settlement Routing Sheet (WC 105) to send the settlement to the Division. Only one copy of the settlement agreement needs to be submitted. If the claimant is unrepresented and has requested a Pro Se Advisement, the Prehearing and Settlement Conference Unit must advise the claimant of their rights before settlement approval. The Prehearing and Conference Settlement Unit provides voluntary, free settlement conferences to help parties reach an agreement.

Settlements can be reopened only if a party can prove the existence of fraud or a mutual mistake of material fact.

REOPENING A CLAIM

Either party can request that a claim be reopened for fraud, overpayment, error, mistake or change of condition. If the parties are unwilling to reopen voluntarily, an Application for Hearing may be filed with the OAC. If reopening voluntarily, the carrier must file a GA.

We would love to hear from you.

Complete our brief survey to let us know how we can better reach you. Your feedback helps us improve our service to you.

surveymonkey.com/r/CODWC

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