DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation
7 CCR 1101-3
WORKERS' COMPENSATION RULES OF PROCEDURE

Rule 1 General Definitions and General Provisions

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

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

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

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

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

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

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

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

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

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

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

1-2 COMPUTATION OF TIME/DATE OF FILING

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

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

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

1-3 NOTARIZATION OF AUTHORIZATION FOR RELEASE OF INFORMATION

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

1-4 SERVICE OF DOCUMENTS

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

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

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

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

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

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

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

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

(4) state the purpose for reviewing the orders.

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

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

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

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

1-6 MEDIATION

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

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

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

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

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

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

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

Rule 5 Claims Adjusting Requirements

5-1 COMPLETION OF DIVISION FORMS

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

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

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

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

(E) In the event compliance with 5-1(C) is prevented by technological errors beyond the control of the filing party, a waiver may be requested by submitting the division-issued

paper form along with a cover letter addressed to the Director identifying the reason for the request. Upon receipt of a request the Division will either accept the paper form or notify the filing party that electronic submission will be required.

5-2 FILING OF EMPLOYERS' FIRST REPORTS OF INJURY

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

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

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

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

(a) Chronic respiratory disease;

(b) Cancer;

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

(d) Nervous system diseases;

(e) Blood borne infectious, contagious diseases.

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

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

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

(E) A statement regarding liability is required for any claim in which a division-issued workers' compensation claim number is assigned or a First Report of Injury should have been filed

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

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

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

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

5-3 INITIAL NOTICE TO CLAIMANT

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

5-4 MEDICAL REPORTS AND RECORDS

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

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

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

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

(4) At the request of the director.

(5) A copy of every medical report not filed with the Division shall be exchanged with all parties within fifteen (15) business days of receipt. A claimant may opt to not receive copies of medical reports from the insurer under this section by providing written notice to the insurer. Such notice may be revoked by the claimant in writing at any time.

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

(C) A party shall have 15 days from the date of mailing to complete, sign, and return a release of medical and/or other relevant information. If a written request for names and addresses of health care providers accompanies the medical release(s), a claimant shall also provide a list of names and addresses of health care providers reasonably

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

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

5-5 ADMISSIONS OF LIABILITY

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

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

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

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

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

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

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

(1) Following any order (except for orders which only involve disfigurement) becoming final which alters benefits being paid under the workers compensation act, an admission consistent with the order shall be timely filed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5-6 TIMELY PAYMENT OF COMPENSATION BENEFITS

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

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

timely and benefits timely paid and for the entire period owed as of the date of the admission, the insurer will be considered in compliance. When benefits are continuing, the payment shall include all benefits which are due as of the date payment is actually issued.

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

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

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

5-7 PERMANENT PARTIAL DISABILITY BENEFIT RATES

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

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

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

5-8 ADMISSION FOR PERMANENT TOTAL DISABILITY BENEFITS

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

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

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

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

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

(a) Death benefits and

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

5-9 REVISING FINAL ADMISSIONS

(A) Within the time limits for objecting to the final admission of liability pursuant to § 8-43-203, C.R.S., the Director may allow an insurer to amend the admission for permanency,

by notifying the parties that an error exists due to a miscalculation, omission, or clerical error.

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

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

5-10 LUMP SUM PAYMENT OF AN AWARD

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

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

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

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

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

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

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

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

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

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

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

5-11 DOCUMENTATION OF APPORTIONMENT

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

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

5-12 RECEIPTS

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

5-13 INFORMATION ON CLAIMS ADJUSTING

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

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

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

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

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

5-14 CORRESPONDENCE FROM THE DIVISION

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

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

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

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

5-15 SURVEYS

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

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

(C) The survey shall include the name of the insurer. The survey shall also have a space for the claimant to sign if communicated by mail. The survey shall include

the following language: “This survey relates to your recent workers’ compensation claim. We would like to find out how satisfied you are with the way your claim was handled.” The survey shall include instructions as to how to return the completed survey to the insurer, and the sentence “Insurers and employers are prohibited by law from taking any disciplinary action or otherwise retaliating against those who respond to this survey.” In addition, the survey shall set forth only the following questions:

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

1 2 3 4 5

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

1 2 3 4 5

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

1 2 3 4 5

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

1 2 3 4 5 NA

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

1 2 3 4 5

(6) The name of the adjuster handling your claim, if known.

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

Rule 6 Modification, Termination or Suspension of Temporary Disability Benefits

6-1 TERMINATION OF TEMPORARY DISABILITY BENEFITS IN CLAIMS ARISING FROM INJURIES ON OR AFTER JULY 1, 1991

(A) In all claims based upon an injury or disease occurring on or after July 1, 1991, an insurer may terminate temporary disability benefits without a hearing by filing an admission of liability form with:

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

(2) a medical report from the authorized treating physician who has provided the primary care, stating the claimant is able to return to regular employment, or

(3) a written report from an employer or the claimant stating the claimant has returned to work and setting forth the wages paid for the work to which the claimant has returned provided such admission of liability admits for temporary partial disability benefits, if the claimant has not returned to work at full wages, or

(4) a letter to the claimant or copy of a written offer delivered to the claimant with a signed certificate indicating service, containing both an offer of modified employment, setting forth duties, wages and hours and a statement from an authorized treating physician that the employment offered is within the claimant's physical restrictions.

(a) A written offer of modified duty may only be used to terminate benefits pursuant to this subsection if:

(i) A copy of the written inquiry to the treating physician is provided to the claimant by the insurer or the insured at the time the authorized treating physician is asked to provide a statement on the claimant's capacity to perform the offered modified duty; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) A copy of a response form prescribed by the Division shall be mailed with a copy of the petition to the claimant and claimant's attorney and the Division. Certification of this mailing shall be filed with the petition.

(C) If the claimant does not file a written objection with the Division within twenty (20) days of the date of mailing of the petition and response form, the Director may grant the insurer's request to suspend, modify or terminate disability benefits as of the date of the petition.

(D) When a claimant files a timely objection to a petition, the insurer shall continue temporary disability benefits at the previously admitted rate until an application for hearing is filed with the Office of Administrative Courts, and the matter is resolved by order. The Director finds that good cause exists to expedite a hearing to be held within sixty (60) days from the date of the setting, because overpayment of benefits may result if the suspension, modification or termination is granted.

(E) When a hearing is continued at the request of the claimant, the administrative law judge shall temporarily grant the relief requested in the petition, pending the continued hearing, if the reports and evidence attached to the petition and objection indicate a reasonable probability of success by the insurer. The continued hearing shall be held no later than thirty (30) days from the date of the request for continuance.

(F) When a hearing is continued at the request of the insurer, temporary disability benefits shall continue until the matter is resolved by order after the hearing.

6-5 MODIFICATION OF TEMPORARY DISABILITY BENEFITS PURSUANT TO STATUTORY OFFSET

An insurer may modify temporary disability benefits to offset social security, disability pension or similar benefits pursuant to statute by filing an admission of liability form with the Division, with documentation which substantiates the offset and figures showing how the amount of the offset was calculated pursuant to statute.

6-6 TERMINATION OR MODIFICATION OF TEMPORARY DISABILITY BENEFITS DUE TO CONFINEMENT

An insurer may terminate or modify temporary disability benefits pursuant to statute, by filing an admission of liability form with the Division with a document issued by a court of criminal jurisdiction, which establishes that the claimant is confined in a jail, prison, or any department of corrections facility as a result of a criminal conviction.

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

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

6-8 FAILURE TO COMPLY WITH REQUIREMENTS OF RULE 6

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

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

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

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

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

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

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

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

Rule 7 Closure of Claims and Petitions to Reopen

7-1 CLOSURE OF CLAIMS

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

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

(1) Is not receiving temporary disability benefits; and

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

(3) has failed to respond within 30 days to a letter from the insurer or the insured asking if the claimant requires additional medical treatment or is claiming permanent impairment. The letter shall be sent after the second missed medical appointment to the claimant and the claimant's attorney if the claimant is

represented. The letter must advise the claimant in bold type and capital letters that failure to respond to the letter within 30 days will result in a final admission being filed. If the claimant timely responds to the letter and objects to closure the insurer may not file a Final Admission of Liability pursuant to this rule.

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

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

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

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

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

(2) Following receipt of a request to close a claim, the Director may issue the order to show cause why the claim should not be closed. If no response is mailed or delivered within 30 days of the date the order was mailed, the claim shall be closed automatically, subject to the reopening provisions of § 8- 43-303, C.R.S. If a response is timely received, the Director may determine whether the claim should remain open. An application for hearing or for a division independent medical examination without further action (i.e., setting and attending a hearing or a division independent medical examination) does not automatically constitute prosecution.

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

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

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

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

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

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

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

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

7-2 PETITIONS TO REOPEN

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

(1) If the other party agrees to reopen the claim the Division shall be notified by the insurer by the filing of an admission.

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

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

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

7-3 SINGLE LIFE EXPECTANCY TABLE

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

28	55.3	67	19.4
29	54.3	68	18.6
30	53.3	69	17.8
31	52.4	70	17.0
32	51.4	71	16.3
33	50.4	72	15.5
34	49.4	73	14.8
35	48.5	74	14.1
36	47.5	75	13.4
37	46.5	76	12.7
38	45.6	77	12.1

Age	Life Expectancy	Age	Life Expectancy
78	11.4	98	3.4
79	10.8	99	3.1
80	10.2	100	2.9
81	9.7	101	2.7
82	9.1	102	2.5
83	8.6	103	2.3
84	8.1	104	2.1
85	7.6	105	1.9
86	7.1	106	1.7
87	6.7	107	1.5
88	6.3	108	1.4
89	5.9	109	1.2
90	5.5	110	1.1
91	5.2	111	1.0
92	4.9		
93	4.6		
94	4.3		
95	4.1		
96	3.8		
97	3.6		

Rule 8 AUTHORIZED TREATING PHYSICIAN

8-1 APPLICABILITY

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

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

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

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

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

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

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

8-2 DESIGNATED PROVIDER LIST

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

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

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

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

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

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

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

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

8-3 EMERGENCY DESIGNATION

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

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

8-4 INFORMATION PROVIDED BY DESIGNATED PROVIDERS

(A) An interested party to a particular claim (as referenced in §8-43-404(5)(a)(I)(A) C.R.S.) includes the injured worker, the attorneys of record, the employer, the insurer, and any third party administrator authorized to handle the specific claim.

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

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

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

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

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

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

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

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

medical provider on the list. The medical provider(s) to whom the injured worker may change is determined by the designated provider list given to the injured worker pursuant to Rule 8-2 or 8-5(C).

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

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

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

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

8-6 TRANSFER OF MEDICAL CARE

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

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

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

appointment could not be scheduled, an appointment is not scheduled or a substitute physician provided, the injured worker may select an authorized treating physician of the worker's choosing.

8-7 CHANGE OF MEDICAL PROVIDER UNDER §8-43-404(5)(A)(VI), C.R.S.

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

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

8-8 INDEPENDENT MEDICAL EXAMINATIONS

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

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

8-9 NOTICE TO CLAIMANT

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

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

8-10 AUDIO RECORDING AND FEES

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

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

(C) The examining physician shall be compensated for conducting the examination pursuant to the medical fee schedule, Rule 18-6(G)(4)-Special Reports. In addition, the examining physician may add a $30 charge for all recorded examinations. The physician shall be entitled to charge $20.00 for each copy of the recording that is provided.

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

8-11 PROCESS

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

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

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

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

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

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

(G) A written allegation from an injured worker that the recording contains medical information that should remain confidential must provide a sufficient level of detail. A sufficient level of detail exists if the written statement provides general information as to what medical information was communicated that should remain confidential, and why the information should remain confidential within the context of the workers'

compensation claim. Raising medical issues contained in the report, or failing to provide sufficient detail shall result in a summary denial of the allegation by an ALJ.

(H) If no timely allegation regarding confidential information pursuant to paragraph (F) is made, the employer/insurer may then request a copy of the recording by providing a written request to the examining physician, explaining that no allegation was made by the injured worker and a copy of the recording may be released to the employer/insurer. A $20 payment to the examining physician shall be included with this request. The examining physician shall provide a copy of the recording within fifteen (15) calendar days of the date the written request is received.

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

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

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

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

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

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

8-12 MAINTENANCE OF THE RECORDINGS

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

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

8-13 DISPUTES

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

Rule 9 Division of Workers' Compensation Dispute Resolution

9-1 DISCOVERY

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

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

(B) Interrogatories and requests for production

(1) Written interrogatories and requests for production of documents may be served upon each adverse party. The number of interrogatories, including the requests for production of documents, to any one party shall not exceed 20.

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

(3) The interrogatories and the requests for production of documents may not be submitted later than 60 days prior to hearing, except for expedited hearings.

(C) Depositions

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

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

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

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

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

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

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

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

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

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

(F) If any party fails to comply with the provisions of this rule and any action governed by it, an administrative law judge may impose sanctions upon such party pursuant to statute and rule. However, attorney fees may be imposed only for violation of a discovery order.

(G) Once an order to compel has been issued and properly served upon the parties, failure to comply with the order to compel shall be presumed willful.

9-2 MEDIATION, SETTLEMENT CONFERENCES, PREHEARING CONFERENCES AND ARBITRATION

(A) Mediation. Parties to a dispute may consent to submit any dispute to mediation. A request for mediation may be presented to either the Division of Workers' Compensation or the Office of Administrative Courts. If all parties agree a conference will be scheduled.

(B) Settlement Conferences. Parties to a dispute may request a settlement conference subject to the limitations set forth in § 8-43-206, C.R.S.

(C) Prehearing Conferences. The Director, administrative law judges in the Office of Administrative Courts, or any party to a claim may request a prehearing conference before a prehearing administrative law judge. Prehearing administrative law judges may order any party to a claim to participate in a prehearing conference.

(1) The issues raised for consideration may be raised by written or oral motion at the time of setting. At the time of setting, the party setting the conference shall notify the prehearing conference unit of the issues to be heard. The prehearing conference unit will notify all other parties of the issues via e-mail.

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

(a) If a party objects to the addition of issues more than two (2) business days after the setting it shall be within the discretion of the prehearing administrative law judge to determine if adequate notice was provided to

the non-moving party and if the time scheduled for the conference is sufficient for the additional issues to be heard.

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

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

(a) A party objecting to the setting of a prehearing conference or refusing to participate in the conference shall e-mail, fax or hand-deliver any objections to the prehearing unit within 2 business days following the date the prehearing conference is set. If the prehearing administrative law judge orders that the prehearing conference proceed as set, the requesting party shall send written notice of the time and place of the prehearing conference to all other parties.

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

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

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

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

9-3 MOTIONS

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

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

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

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

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

(5) Closure orders;

(6) Matters involving uninsured employers;

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

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

(9) Disputes regarding medical payments

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

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

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

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

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

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

9-4 PRIVILEGES AND PRIVILEGE LOGS

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

1. The date of the item for which the privilege is being asserted;
2. The author and recipient of the item;
3. A description of the subject matter sufficient to explain, without disclosing the substance of the allegedly privileged material, why the item qualifies for the asserted privilege;
4. The legal and factual basis for the claim of privilege;
5. If the privileged item contains a communication, the names and titles of the parties to that communication;

9-5 TRUST DEPOSITS AND SURETY BONDS

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

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

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

9-6 CONSOLIDATION AND MERGER OF CLAIMS

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

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

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

9-7 PENALTY PROCEDURES

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

9-8 ATTORNEY REPRESENTATION

(A) To represent a party in a claim at the Division of Workers' Compensation, an attorney shall file an entry of appearance with the Division.

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

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

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

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

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

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

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

9-9 SETTLEMENT PROCEDURES

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

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

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

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

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

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

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

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

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

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

9-10 CLAIM FILES

The file at the Division of Workers' Compensation will be retained in its original form at the Division until the claim is closed and is not subject to subpoena for administrative hearings. A scanned electronic version of the file will be retained for at least seven years from the date of closure. Certified copies of any documents in the Division file can be tendered by a party to the office of administrative courts and shall be considered self-authenticating. Parties may obtain certified copies of documents in the Division file by contacting the Division of Workers' Compensation, customer service section. Absent extraordinary circumstances, no employee of the Division of Workers' Compensation shall be expected or required to testify at a hearing.