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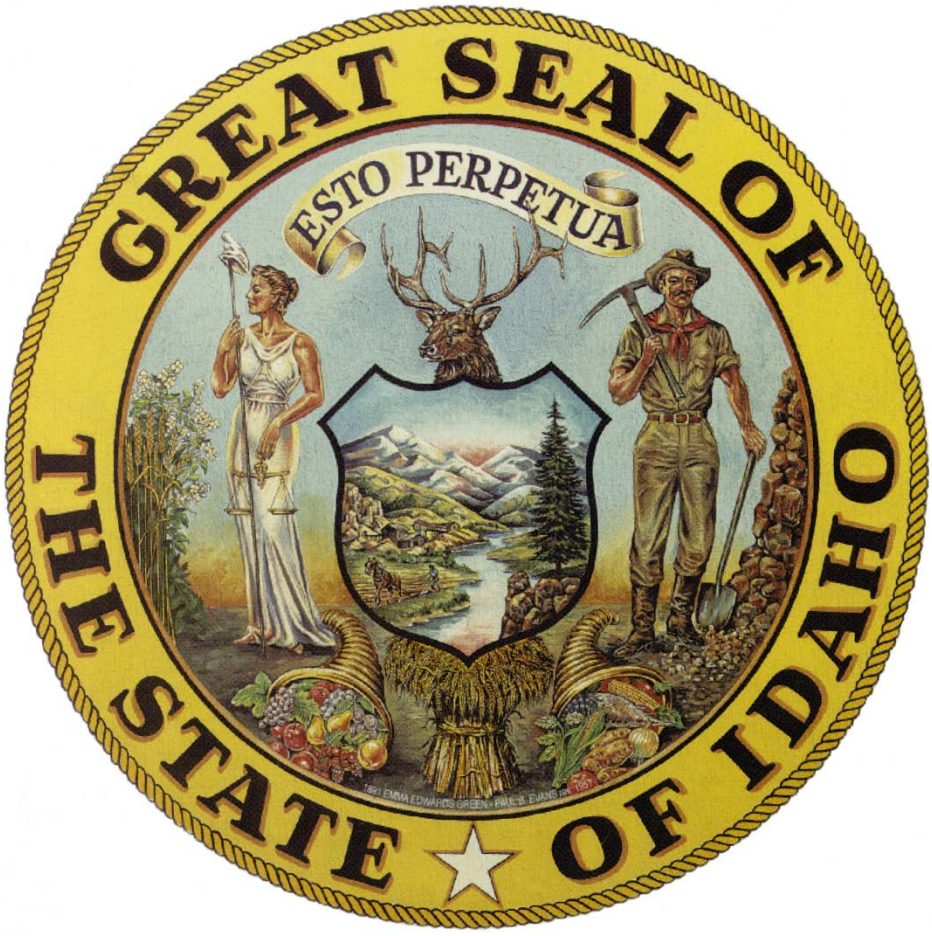
Idaho Industrial Commission Audit Guidelines



NOVEMBER 2017

THESE GUIDELINES ARE INTENDED TO PROVIDE GENERAL INFORMATION TO THE INDUSTRY ABOUT THE IDAHO WORKERS' COMPENSATION AUDIT PROCESS AND ARE NOT INTENDED AS A SUBSTITUTE FOR LEGAL ADVICE.

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I. DEFINITIONS

Adequate Personnel – Having in-state staff or licensed, resident claims adjusters to service and make decisions regarding claims pursuant to I.C. §72-305, including, but not limited to investigating and adjusting all claims for compensation; paying all compensation benefits due; accepting service of claims, applications for hearings, orders of the Commission and all process which may be issued under the Workers' Compensation Law; enter into compensation agreements and lump sum settlements with claimants; and provide, at the insurance carrier's expense, necessary forms to any worker who wishes to file a claim under the Workers' Compensation Law. Sources: **I.C. §72-305** and **IDAPA 17.02.10.051.01 & 17.02.11.051.01**

Adjuster – An individual who adjusts workers' compensation claims. Source: **IDAPA 17.02.07.10.01**

Audit Criteria – Criteria used during compliance audits; as outlined in the Compliance Categories, chapter IV, of the Audit Guidelines.

Change of Status Events –Events which occur during the processing of a claim that require proper notice to the Commission and the Claimant. Change of Status events include, but are not limited to the following: acceptance of a claim, denial of a claim, starting benefits, stopping benefits, reducing benefits, changes to Average Weekly Wage or Temporary Total Disability rates, Maximum Medical Improvement, and an award of Permanent Partial Impairment.

Change of Status Notice (COS) – A workman shall receive written notice within fifteen (15) days of any change of status or condition. Source: **I.C. §72-806**

Claim – A written request made with an employer for benefits payable under the Idaho Workers' Compensation Act. The notice of injury may also include the claim. ***See also: Notice*** Source: **I.C. §72-702 & I.C. §72-703**

Claimant – A worker who is seeking to recover benefits under the Workers' Compensation Law. Source: **IDAPA 17.02.07.10.03.**

Claims Administrator – An organization, including insurers, third-party administrators, independent adjusters, or self-insured employers, that service workers' compensation claims. Source: **IDAPA 17.02.10.010.02**

Closure – For time-loss claims, closure means that the file will be retired following an audit by the Commission. Source: **IDAPA 17.02.06.021.01(a)**

Commission – The Idaho Industrial Commission.

Compliance Audit – A formal review, evaluation, and assessment by the Commission of an insurer or self-insured employer's compliance with its duties under the Idaho Workers' Compensation Law and Commission Rules.

Electronic Data Interchange (EDI) – A computer-to-computer exchange of data in a standardized format.

Employer – Any person who has expressly or impliedly hired or contracted the services of another including, but not limited to, contractors, subcontractors, the owner or lessee of premises, or other person who is virtually the proprietor or operator of the business. Source: **I.C. §72-102(13)**

First Report of Injury or Illness (FROI) –The first filing of information with the Industrial Commission that a reportable workplace injury has occurred or an occupational disease has been manifested, as required by **I.C. §72-602(1)**

Filed or Reported –The date written notice is received by the Commission.

IAIABC EDI Release 3.0 – The IAIABC authored EDI claims release 3.0 standards that cover the transmission of claims (FROI and SROI) information through electronic reporting.

Idaho Administrative Procedures Act (IDAPA) – State of Idaho agency rules. When used throughout this guide, IDAPA is referring to the agency rules for the Idaho Industrial Commission.

Impairment Rated Claims – Claims where a physician establishes an impairment rating for the injured worker. Source: **IDAPA 17.02. 06.021**

Indemnity Benefits – All payments made to or on behalf of workers' compensation claimants, including temporary or permanent disability benefits, death benefits paid to dependents, retraining benefits, and any other type of income benefits, but excluding medical and related benefits. Source: **IDAPA 17.02.10.010.03**

Indemnity Claim – Any claim made for the payment of indemnity benefits.

Law – Idaho Workers' Compensation Law, Title 72, Sections 101, et. seq., Idaho Code.

Legacy Claim – A claim where the First Report of Injury was filed prior to November 4, 2017.

Medical Only Claim – A claim where an injured worker has neither suffered a disability lasting more than five (5) calendar days as a result of a job-related injury or occupational disease, nor been admitted to a hospital as an in-patient. The worker received no indemnity benefits.

Medical Report – Includes, without limitation, all bills, chart notes, surgical records, testing results, treatment records, hospital records, prescriptions, and medication records. Source: **IDAPA 17.02.04.322.01 (b)**

Non-compliance – Failure to comply with the Idaho Workers' Compensation Law or IDAPA Rules.

Notice – Actual notice or, where required, written notice of an event.. Source: **IDAPA 17.02.07.010.09**

Payor – The legal entity responsible for paying benefits under the Idaho Workers' Compensation Law.

Self-insured Employer - An employer who has been authorized by the Commission under the provisions of Title 72 of the Idaho Code to self-insure their liability to their employees covered by this law.

Summary of Payments (SOP) – A summary listing the type and amount of compensation payments made or to be made to the Claimant.

Surety - Any insurer authorized by the Commission to insure or guarantee payment of workers' compensation liability of employers in the state of Idaho; also included are the Idaho State Insurance Fund, a self-insured employer, and an inter-insurance exchange.

Temporary Partial Disability (TPD) – A reduced income benefit calculated as sixty-seven percent (67%) of the decrease in wage-earning capacity payable to injured

workers who continue to work while in recovery. In no event, is this benefit to exceed the maximum income benefits payable for total disability. Source: **I.C. §72-408**

Temporary Total Disability (TTD) – An income benefit for total disability during the period of recovery.

Termination of Disability –The date upon which the obligation of the Employer/Surety/Adjuster becomes certain as to duration and amount whether by settlement, decision or periodic payments in the ordinary course of claims processing. If resolved by lump sum settlement (LSS), the termination of disability shall occur on the date the LSS is approved and an order approving it is filed by the Industrial Commission. If resolved by decision, the termination of disability shall occur on the date the decision resolving all issues becomes final. Source: **IDAPA 17.02.06.021(h)**

Time Loss Claim – The injured worker will suffer, or has suffered, a disability lasting more than five calendar days as a result of a job-related injury or occupational disease, or the injured worker requires, or required, in-patient treatment as a result of such injury or disease. Source: **IDAPA 17.02.06.021(g)**

Waiver – Approval from the Commission waiving certain requirements under the Idaho Workers' Compensation Law or Commission Rules for a surety.

II. OVERVIEW OF AUDIT PROCESS

The responsibility and regulatory accountability for compliance with the Idaho Workers' Compensation Laws and Rules rests with the insurance carrier/self-insured employer and it is the responsibility of the insurance carrier/self-insured employer to demonstrate compliance to the Commission. The term "insurer," when used in this Guide, includes an insurance carrier/self-insured employer and their claims adjusting agent or third-party administrator (TPA).

The purpose of this Audit Guide is to assist those responsible for adjusting claims in understanding the Commission's expectations regarding adjusting and the adjusting practices needed to achieve and maintain acceptable compliance levels. This Guide lists the regulatory criteria governing compliance and outlines the audit inquiries used by Commission personnel to evaluate compliance.

The Commission's Benefits Department Surety Audit Program conducts compliance audits. The audit is an autonomous process. Commission auditors independently analyze claim practices, assess compliance, and report findings.

Authority of the Commission to adopt rules:
I.C. §72-508:
"AUTHORITY TO ADOPT RULES AND REGULATIONS. Pursuant to the provisions of chapter 52, title 67, Idaho Code, the commission shall have authority to promulgate and adopt reasonable rules and regulations for effecting the purposes of this act. Notwithstanding the provisions of chapter 52, title 67, Idaho Code, the commission shall have authority to promulgate and adopt reasonable rules and regulations involving judicial matters. In administrative matters and all other matters, the commission shall be bound by the provisions of chapter 52, title 67, Idaho Code. Rules and regulations as promulgated and adopted, if not inconsistent with law, shall be binding in the administration of this law."

IDAPA 17 Industrial Commission Rules
The Industrial Commission's Rules for sureties are found at IDAPA 17, Title 2, Chapters one (1) through eleven (11).

III. COMPLIANCE AUDITS

Measurement of compliance is based on data obtained from the Commission's records and the insurer's files and records. The objective of the compliance audit is to measure the insurer's or self-insured employer's compliance with Idaho Laws and Rules in the identified categories in Section IV, and to report insurer or self-insured employer compliance levels in each of those categories.

Selection of Insurers for Audit

An insurer or self-insured employer may be selected for an audit based on:

- Number of indemnity claims filed with the Commission
- Past or current performance
- Complaints
- Random selection
- At the request of an insurer or self-insurer

Types of Audits

Once an insurer or self-insurer is identified for an audit, the following types of audits may be conducted:

- Letter Audit
- First Report of Injury (FROI) Audit
- On-Site Audit

A Letter Audit may consist of an audit of one particular claim, employer, or surety based upon information received by the Commission. This type of audit may be conducted due to non-compliance in reporting, non-response to Commission inquiries, or complaints from an outside party which must be addressed outside of an on-site audit. This type of audit may result in a Preliminary Administrative Audit Findings letter being issued to address the current issue(s).

A FROI audit will consist of reviewing the FROIs filed with the Commission for a specific period of time compared to the insurer's list of claims filed for the same period of time. This type of audit is typically prompted when a pattern of unfiled or untimely filed claims has been identified by the Commission. A FROI audit may result in a Preliminary Administrative Audit Findings letter being issued or provide evidence to initiate an on-site audit.

An on-site audit will consist of reviewing claim files for compliance with the compliance categories listed in Section IV of this Audit Guide.

Audit Scope

Claims may be reviewed for compliance with the Laws and Rules on any or all of the following matters:

- Timely reporting by insurers of FROIs/claims required to be filed with the Commission
- Timely and accurate filing of Change of Status notices to required parties
- Accurate calculation of Average Weekly Wage
- Accurate calculation of compensation rate
- Timely compensation payments
- Prompt medical benefit payment or denial of payment
- Prompt and properly supported termination of benefits
- Accurate calculation of Permanent Partial Disability Benefits based on Impairment
- In-State adjusting practices
- Proper check issuance and waiver verification
- Access to claim files
- Responsiveness to Commission inquiries
- Proper notification of the in-state claims administrator
- Adjusting by authorized personnel
- Appropriate in-state personnel to promptly adjust claims
- Prompt adjusting practices
- Explanation of Benefits/Explanation of Review contains local contact information
- Interim Summaries of Payments on file at the Commission
- Proper notification of in-state signatories/adjusters
- Copies of initial payments sent to the Commission
- Summaries of Payments submitted within 120 days of termination of disability
- Required information provided on First Report of Injury filings
- Proper date stamping of documents in claim files
- Identification of proper surety on claims correspondence
- Adjuster authority
- Claims correspondence

Audit Sample

The insurer's list of claims and Commission records are used to select a sample of claims to audit. The sample is typically taken from claims with dates of injury occurring 12-15

months preceding the date of the audit. The sample size may vary according to the number of claims on record during the selected time period. These claims will be provided by the insurer to the Commission in electronic format and will be matched with the claims on file at the Commission. A comparison of the claims will be made to determine whether claims were filed timely and whether all claims are on file.

The Commission will utilize a closed claims report to determine whether Initial Payments were appropriately filed and whether Summaries of Payments were timely filed. The determination whether the Initial Payment was timely filed can only be measured by using the Industrial Commission closure date as it is not known whether a claim will require an initial payment until the claim is closed. The timely filing of Summaries of Payments can only be measured by using the Industrial Commission closure date as it is not known whether a claim will require a Summary of Payments until the claim is closed. The Industrial Commission closure date is the date stamped on the returned copy.

Claims selected for full review are randomly selected or have been flagged at the Commission for further review. Any claim filed with the insurer may be audited without regard to file date or date of injury. ***During every on-site audit, all total permanent disability claims and fatality claims will be audited.***

On-Site Audit Process

The Commission will provide an initial notice of the audit to the insurer not less than four (4) weeks prior to the auditor's arrival on-site, unless the Commission determines circumstances warrant otherwise. The notice will describe the audit process generally. Included with the audit notice will be a Surety Procedures Questionnaire (***See Appendix B***), an IDAPA Rules Audit Questionnaire (***See Appendix C***) and a copy of this Audit Guide. The insurer will be responsible for answering the questions on the questionnaires and returning them to the Commission two (2) weeks prior to the audit. The notice will identify the surety to be audited, confirm the dates the auditor(s) will be on site, and identify the information required to be provided to the auditor(s) prior to and/or at the time of the auditor's arrival on site. Such information may include but is not limited to:

- Answers to questions regarding the insurer's operations
- Insurer's original claim files and access to all electronic claim data
- Wage verification for Average Weekly Wage determinations
- Wage records for claims where Claimant is working with restrictions
- A ledger of all compensation payments (or access to print this information)
- Access to all received medical bills
- A copy of and/or access to adjuster's original claim adjusting notes on each claim

- Training, instruction and/or insurer procedure manuals as requested
- List of all claims for the subject surety based upon the audit timeframe
- A list of any and all open claims for the audit timeframe
- A list of denied claims for the audit timeframe
- Insurer/Third-Party Administrator operating agreements/instructions

Initial Meeting

During the initial audit meeting with the insurer, self-insured employer or their Third-Party Administrator, the auditor will review the audit process and answer any questions. Any preliminary audit findings discovered during audit preparation will be discussed. The auditor will review the insurer's operations to gain an understanding of the information available in the insurer's claim adjusting system. The Third-Party Administrator may extend an invitation to the carrier to attend.

Frequency of Audits

Frequency of audits will generally depend on the insurer's achieving and maintaining satisfactory compliance levels. Insurers may expect increased audit frequency if compliance levels remain unsatisfactory or below the industry standard.

IV. COMPLIANCE CATEGORIES

Auditors will measure and report insurer or self-insured employer compliance levels in the following **Compliance Categories.** Insurers or self-insured employers who have a finding of noncompliance level in any of the categories may be subject to the following:

- Preliminary Administrative Audit Findings (*See Section V*)
- Revocation of any out-of-state Check Waiver
- Revocation of any authority to issue income benefits on other than a weekly basis
- Show Cause Hearing to determine eligibility to continue as surety/self-insured

1. Authorized Adjusting Personnel Violations
I.C. §72-305; IDAPA 17.02.10.051; IDAPA 17.02.11.051

All insurance carriers and licensed adjusters servicing Idaho workers' compensation claims shall maintain an office within the state of Idaho staffed by adequate personnel to conduct business. The insurance carrier shall authorize and require a member of its in-state staff or a licensed, resident claims adjuster to service and make decisions regarding claims pursuant to I.C. § 72-305. Answering machines, answering services, or toll-free numbers outside of the state will not suffice. The in-state adjuster's authority shall include, but is not limited to, the following responsibilities: Investigate and adjust all claims for compensation; pay all compensation benefits due; accept service of claims, applications for hearings, orders of the Commission, and all processes which may be issued under the Workers' Compensation Law; enter into compensation agreements and lump sum settlements with Claimants; and provide at the insurance carrier's expense necessary forms to any worker who wishes to file a claim under the Workers' Compensation Law. Reserve setting and conducting three-point contacts are deemed to be adjusting functions to be performed by the in-state adjuster. Medical consultants, which include Nurse Case Managers, are only authorized to offer medical advice per I.C. §72-305. Contracted Medical Bill Reviewers shall have authority to adjust medical bills to the Idaho Medical Fee Schedule, but not to make determinations on whether to issue payment. For further guidance on Adjusting by Unauthorized Personnel ***see Appendix D***: In-State Adjusting Requirements Guidance Memorandum dated May 2013, and ***Appendix E***: Payment of Benefits Under Deductible Policies and In-State Adjusting Requirements Guidance Memorandum dated May 2016.

Criteria Used to Determine Compliance

- Review of adjuster claim notes for determinations on adjusting authority
- Review of payment ledgers

- Review of Change of Status notices
- Review of claim documents/correspondence

Criteria to qualify for a Non-Compliance Finding

- One (1) non-complying event

2. <u>Checks Issued Out-of-State Without An Approved Waiver</u>
IDAPA 17.02.10.051.07; IDAPA 17.02.11.051.07

The Commission may, upon receipt of a written Application for Waiver, grant permission for an insurance carrier to sign and issue checks outside the state of Idaho.

Criteria Used to Determine Compliance

- Review Commission records to determine whether an Application of Waiver has been received and approved
- Review of any compliance issues

Criteria to qualify for a Non-Compliance Finding

- One (1) non-complying event

3. <u>Lack of Immediate Access to Claim Files by In-State Claims Administrator</u>
IDAPA 17.02.10.051.02; IDAPA 17.02.11.051.02

All Idaho Workers' Compensation claim files shall be maintained within the state of Idaho in either hard copy or immediately accessible electronic format.

Criteria Used to Determine Compliance

- Surety response to Commission inquiry on a claim file
- Review of claim notes related to requests for information – i.e. copy of a payment ledger, copy of medical bills including Explanation of Review/Explanation of Benefits
- Availability of documents when auditing on-site

Criteria to qualify for a Non-Compliance Finding

- One (1) non-complying event

4. <u>Non-Prompt Response to Commission Inquiries Regarding Claim Status</u>
IDAPA 17.02.06.021.04; IDAPA 17.02.10.013.05; IDAPA 17.02.11.014.05

In the event the Commission requests additional information when auditing the Summary of Payments, whether in writing or telephonic, the employer/surety/adjuster shall submit the requested information within fifteen (15) working days. For all other Commission inquiries, a response is expected in a timely manner.

Criteria Used to Determine Compliance

- Surety response to Commission inquiry on a claim file or request for additional information

Criteria to qualify for a Non-Compliance Finding

- One (1) non-complying event

5. Non-Prompt Indemnity Payments
I.C. §72-304; I.C. §72-402; IDAPA 17.02.10.051.09; IDAPA 17.02.11.051.09

Income benefits are to be paid to Claimant on a weekly basis, unless otherwise approved by the Commission. The first payment of income benefits under I.C. §72-408, shall constitute application by the insurance carrier/self-insured employer for a waiver to pay Temporary Total Disability (TTD) benefits on a bi-weekly basis, Temporary Partial Disability (TPD) benefits on other than a weekly basis, and Permanent Partial Disability (PPD) benefits every twenty-eight (28) days. Temporary Partial Disability payments owed for a particular pay period shall issue no later than seven (7) days following the date on which the employee is ordinarily paid for that pay period. For the purposes of audit, the Initial Payment is required to be issued within twenty-eight (28) days from the date of disability. Each indemnity payment will be measured on a seven (7) day period for timeliness.

Criteria Used to Determine Compliance

- Review of First Report of Injury, medical reports, and claim notes to determine beginning date of disability
- Review of payment ledger to confirm timeliness of payments

Criteria to qualify for a Non-Compliance Finding

- 5% of the claims reviewed at the audit are non-compliant if the surety/self-insured employer has NOT been audited within the previous twenty-four (24) months.
- 3% of the claims reviewed at the audit are noncompliant if the surety/self-insured employer has been audited within the previous twenty-four (24) months.

6. Change of Status Notice not sent or sent Untimely to Claimant
I.C. §72-806; IDAPA 17.02.08.061.01

A workman shall receive written notice within fifteen (15) days of any change of status. If there is reference to a medical opinion, a copy of the medical report referenced needs to be included. Each "trigger event" will be considered when auditing the claim record to determine whether Claimant was provided timely notice of each event. For further information on the issuance of Change of Status notices, ***see Appendix F***: Notice of Change of Status Guidance Memorandum dated February 2014.

Criteria Used to Determine Compliance

- Review of claim notes to determine applicable events requiring notice to the injured worker
- Review of Change of Status in claim file and at the Commission

Criteria to qualify for a Non-Compliance Finding

- 5% of the claims reviewed at the audit are non-compliant if the surety/self-insured employer has NOT been audited within the previous twenty-four (24) months.
- 3% of the claims reviewed at the audit are non-compliant if the surety/self-insured employer has been audited within the previous twenty-four (24) months.

7. Untimely Notice to Commission of Changes in In-State Claims Administrator for a Covered Employer
IDAPA 17.02.10.013.03(a)

Each authorized insurance carrier shall notify the Commission Secretary in writing of any change of the designated resident adjuster(s) for every insured Idaho employer within fifteen (15) days of such change.

Criteria Used to Determine Compliance

- Review of notifications on file at the Commission

Criteria to qualify for a Non-Compliance Finding

- One (1) non-complying event

8. First Reports of Injury are not on Record at the Commission
I.C. §72-602

The First Report of Injury is due to the Commission as soon as practicable, but not later than ten (10) days after the occurrence of an injury or occupational disease requiring treatment by a physician or resulting in absence from work for one (1) day or more.

Criteria Used to Determine Compliance

- Review of claims list supplied by the surety/self-insured employer/administrator prior to the audit to compare to claims on file with the Commission
- Review of efforts made by surety/self-insured employer/administrator to enforce employer reporting obligations

Criteria to qualify for a Non-Compliance Finding

- 2% of the claims on file for the audit period are non-compliant if the surety/self-insured employer has NOT been audited within the previous twenty-four (24) months.
- 1% of the claims on file for the audit period are non-compliant if the surety/self-insured employer has been audited within the previous twenty-four (24) months.

9. Insufficient In-State Personnel to Promptly Adjust Claims
IDAPA 17.02.10.051.01(a); IDAPA 17.02.11.051.01

All insurance carriers and licensed adjusters servicing Idaho workers' compensation claims shall maintain an office within the state of Idaho. The offices shall be staffed by adequate personnel to conduct business. Adequacy may be influenced by factors including but not limited to caseload and training.

Criteria Used to Determine Compliance

- Number of findings issued during audit period
- Non-prompt adjusting and issuance of payments

Criteria to qualify for a Non-Compliance Finding

- One (1) non-complying event

10. Claims Adjusting Correspondence not Authorized from the In-State Office
I.C. §72-305; IDAPA 17.02.10.051.03; IDAPA 17.02.11.051.03

All adjusting decisions must originate in-state although correspondence memorializing in-state adjusting decisions may be prepared and mailed from out of state.

Criteria Used to Determine Compliance

- Review of adjuster claim notes
- Review of claim documentation and correspondence

Criteria to qualify for a Non-Compliance Finding

- One (1) non-complying event

11. Non-Prompt Adjusting
I.C. §72-305; I.C. §72-402; IDAPA 17.02.10.051.09; IDAPA 17.02.11.051.09

An initial decision to accept or deny a claim for an injury or occupational disease must be made within thirty (30) days of the date the claims administrator receives knowledge of the same. Notice of the decision shall be given in accordance with I.C. §72-806. In no event shall disability payments be paid later than four (4) weeks or twenty-eight (28) days from the date of disability. All adjusting decisions are expected to be made promptly including, but not limited to, responding to claimant inquiries, responding to requests from medical providers, and initial compensability determinations.

Criteria Used to Determine Compliance

- Review of adjuster claim notes
- Review of receipt of claim by administrator
- Review of payment ledger
- Review of medical records

Criteria to qualify for a Non-Compliance Finding

- 10% of the claims reviewed at the audit are non-compliant if the surety/self-insured employer has NOT been audited within the previous twenty-four (24) months.
- 8% of the claims reviewed at the audit are non-compliant if the surety/self-insured employer has been audited within the previous twenty-four (24) months.

12. Untimely Medical Payments
I.C. §72-304; IDAPA 17.02.09.035.04; IDAPA 17.02.10.051.09; IDAPA 17.02.11.051.09

Unless the Payor denies liability for the claim or sends a timely Preliminary Objection, a Request for Clarification, or both, as to any charge, the Payor shall pay the charge within thirty (30) calendar days of receipt of the bill.

Criteria Used to Determine Compliance

- Review of payment ledger
- Review of Explanation of Benefit (EOB)/Explanation of Review (EOR)
- Review of date-stamped medical billing

Criteria to qualify for a Non-Compliance Finding

- 15% of the claims reviewed at the audit are non-compliant if the surety/self-insured employer has NOT been audited within the previous twenty-four (24) months.
- 10% of the claims reviewed at the audit are non-compliant if the surety/self-insured employer has been audited within the previous twenty-four (24) months.

13. Explanation of Benefits/Explanation of Review (EOB/EOR) does not include Local Contact Information
I.C. §72-305; IDAPA 17.02.09.035.06(c)

Each Preliminary Objection and Request for Clarification shall contain the name, address and phone number of the individual located within the state of Idaho that the Provider may contact regarding the Preliminary Objection or Request for Clarification. The name of the adjuster is not required if the local address and phone number are contained on the Explanation of Benefits/Explanation of Review.

Criteria Used to Determine Compliance

- Review of all Explanation of Benefits/Explanation of Review of each claim audited

Criteria to qualify for a Non-Compliance Finding

- One (1) non-complying event

14. Interim Summaries of Payments not on file at the Commission
IDAPA 17.02.06.021.02

All fatal claims and permanent total disability claims require interim Summaries of Payments to be filed annually with the Commission, within the first quarter of each calendar year.

Criteria Used to Determine Compliance

- Review of Fatal and Permanent Total Disability claims on file with the Commission

Criteria to qualify for a Non-Compliance Finding

- One (1) non-complying event

15. Untimely Notification of In-State Signatories/Adjusters
I.C. §72-305; IDAPA 17.02.10.051.01; IDAPA 17.02.11.051.01

As staffing changes occur AND at least annually, the insurance carrier or licensed adjuster shall submit to the Industrial Commission Secretary the names of those authorized to make decisions regarding claims pursuant to I.C. §72-305.

Criteria Used to Determine Compliance

- Review of annual report or updated lists of adjusters received at the Commission

Criteria to qualify for a Non-Compliance Finding

- One (1) non-complying event

16. First Reports of Injury are not sent to the Commission by Employer Within Ten (10) Days of Accident, Injury, or Occupational Disease
I.C. §72-602

The First Report of Injury is due to the Commission as soon as practicable, but not later than ten (10) days after the occurrence of an injury or occupational disease requiring treatment by a physician or resulting in absence from work for one (1) day or more.

Criteria Used to Determine Compliance

- Review of claims list supplied by the surety/self-insured employer/administrator prior to the audit

- Review of claims filed with the Commission during the audit period
- Review of efforts made by surety/self-insured employer/administrator to enforce employer reporting obligations

Criteria to qualify for a Non-Compliance Finding

- 5% of the claims on file for the audit period are non-compliant if the surety/self-insured employer has NOT been audited within the previous twenty-four (24) months.
- 3% of the claims on file for the audit period are non-compliant if the surety/self-insured employer has been audited within the previous twenty-four (24) months.
- Failure to adequately enforce timely employer reporting of injuries

17. Initial Payment Copy not sent to the Commission IDAPA 17.02.10.051.08; IDAPA 17.02.11.051.08

Copies of checks and/or electronically reproducible copies of the information contained on the checks must be maintained in the in-state files for Industrial Commission audit purposes. A copy of the first check showing the date it was issued, shall be sent to the Industrial Commission the same day.

Criteria Used to Determine Compliance

- Review of claims closed during the audit period and Commission database to determine if a copy was submitted. *NOTE: The Initial Payment measurement can only be achieved by using the Industrial Commission closure date as it is not known whether a claim will require an Initial Payment until the claim is closed.

Criteria to qualify for a Non-Compliance Finding

- 10% of the claims on file for the audit period are non-compliant if the surety/self-insured employer has NOT been audited within the previous twenty-four (24) months.
- 5% of the claims on file for the audit period are non-compliant if the surety/self-insured employer has been audited within the previous twenty-four (24) months.

18. Change of Status Notice not Copied to the Commission
I.C. §72-806; IDAPA 17.02.08.061.05

The party giving notice pursuant to I.C. §72-806 shall send a copy of any such notice to the Industrial Commission, the employer, and the worker's attorney if the worker is represented, at the same time notice is sent to the worker.

Criteria Used to Determine Compliance

- Review of Change of Status notices issued in the claim file
- Review of the Commission database

Criteria to qualify for a Non-Compliance Finding

- 10% of the claims reviewed at the audit are non-compliant if the surety/self-insured employer has NOT been audited within the previous twenty-four (24) months.
- 5% of the claims reviewed at the audit are non-compliant if the surety/self-insured employer has been audited within the previous twenty-four (24) months.

19. Change of Status Notice does not Contain Required Elements
I.C. §72-806; IDAPA 17.02.08.061.03

Any notice to a worker required by I.C. §72-806 shall be mailed within ten (10) days by regular United States Mail to the last known address of the worker, as shown in the records of the party required to give notice as set forth above. The Notice shall be given on IC Form 8, or in a format substantially similar. Notice shall include, but is not limited to the following: Injured Worker Name/Address, SSN or last 4 digits of SSN, Date of Injury, Employer Name, Surety Name, and Medical Report as required.

Criteria Used to Determine Compliance

- Review of Change of Status notices in claim files

Criteria to qualify for a Non-Compliance Finding

- 10% of the claims reviewed at the audit are non-compliant if the surety/self-insured employer has NOT been audited within the previous twenty-four (24) months.
- 5% of the claims reviewed at the audit are non-compliant if the surety/self-insured employer has been audited within the previous twenty-four (24) months.

20. Summaries of Payments Filed with the Commission after 120 Days IDAPA 17.02.06.021.02

A Summary of Payment shall be filed, in duplicate, by the employer/surety/administrator within one hundred twenty (120) days of termination of disability for all time-loss claims upon which an employer/surety/administrator has made payments, including wages in lieu. Claims resolved by lump sum settlement do not require a Summary of Payment. Supporting documentation shall be attached to any Summary of Payment filed with the Commission. *NOTE: The timely filing of Summary of Payments can only be measured by using the Industrial Commission closure date as it is not known whether a claim will require a Summary of Payments until the claim is closed.

Criteria Used to Determine Compliance

- Review of claims closed during the audit period to identify date of last disability payment and filing of the Summary of Payment with the Commission

Criteria to qualify for a Non-Compliance Finding

- 12% of the claims on file for the audit period are non-compliant if the surety/self-insured employer has NOT been audited within the previous twenty-four (24) months.
- 10% of the claims on file for the audit period are non-compliant if the surety/self-insured employer has been audited within the previous twenty-four (24) months.

21. Hard Copy Documents in Claim File not Properly Date Stamped IDAPA 17.02.10.051.04; IDAPA 17.02.11.051.04

Each of the documents listed in Subsections 051.02 [First Report of Injury, claim for benefits, copies of bills for medical care, copy of lost-time computations, if applicable, correspondence reflecting reasons for any delays in payments, employer's supplemental report, and medical reports] and 051.03 [all original correspondence involving adjusting decisions] shall be date-stamped with the name of the receiving office on the day received, and by each receiving agent or vendor acting on behalf of the claims office.

Criteria Used to Determine Compliance

- Review of claim file documents pursuant to Subsections 051.02 and 051.03 for appropriate date stamping

Criteria to qualify for a Non-Compliance Finding

- 10% of the claims reviewed at the audit are non-compliant if the surety/self-insured employer has NOT been audited within the previous twenty-four (24) months.
- 5% of the claims reviewed at the audit are non-compliant if the surety/self-insured employer has been audited within the previous twenty-four (24) months.

22. Claims Administrator does not Consistently Classify and Identify the Correct Surety on Claims
IDAPA 17.02.10.013.03(b)

Each authorized insurance carrier will ensure that every in-state adjuster can classify and identify all claims adjusted on behalf of said insurance carrier, and that the in-state adjuster will provide such information to the Industrial Commission upon request.

Criteria Used to Determine Compliance

- Review of response to Commission inquiries
- Review of First Reports of Injury received at Commission for surety and/or claims administrator and mandatory element filings

Criteria to qualify for a Non-Compliance Finding

- One (1) non-complying event

23. Failure to Pay Benefits in Accordance with Statute and Rule
I.C. §72-402; I.C. §72-404; I.C. §72-408; I.C. §72-409; I.C. §72-413; I.C. §72-418; I.C. §72-419; I.C. 72-428; IDAPA 17.02.10.051.09; IDAPA 17.02.11.051.09

Payment for lump sum settlement, temporary total or temporary partial disability, death benefits and permanent partial disability shall be paid and calculated pursuant to the applicable statute. Average Weekly Wage shall be calculated according to applicable statutes. TPD is to be calculated according to the worker's pay period.

Criteria Used to Determine Compliance

- Review of AWW calculations
- Review of TTD calculations
- Review of TPD calculations
- Review of PPD calculations

- Review of timely lump sum settlement payment
- Review of death benefit determination and payments

Criteria for a Non-Compliance Finding

- One (1) non-complying event

24. Improper Recovery of Voluntary Payments
I.C. §72-316; I.C § 72-806; IDAPA 17.02.08.061.05

Recovery of voluntary payments determined to be in excess of the amount actually owed are subject to the prior approval of the Commission and can only be deducted from the amount yet owing; provided that the deduction is made by shortening the duration of weekly income payments, rather than by reducing the amount of weekly income payments. Prior approval of the recovery must be requested by the simultaneous submission of a Notice of Change of Status to the Claimant and to the Commission. The surety may not exercise any collection action against the Claimant under another court's jurisdiction. ***See Appendix G:*** Procedure for recovery of overpayments memorandum dated August 2017.

Criteria Used to Determine Compliance

- Review of all benefits paid
- Review of Overpayment Change of Status notices

Criteria for a Non-Compliance Finding

- One (1) non-complying event

25. Employers with Deductible Policies are Paying Benefits Directly and/or Adjusting Out of State
I.C. § 72-301; I.C. § 72-306A; I.C. § 72-319; IDAPA 17.02.10.051.01

Payment of benefits must emanate from surety, or from surety via its TPA. Pursuant to I.C. § 72-306A, a surety is required to initially fund all losses and then seek reimbursement for such losses paid, up to the amount of the stated deductible, from the policyholder. All aspects of handling and adjusting workers' compensation claims must be conducted by an Idaho licensed in-state adjuster or by the surety's in-house, in-state adjuster. ***See Appendix E***: Payment of Benefits Under Deductible Policies and In-State Adjusting Requirements Guidance Memorandum dated May 2016.

Criteria Used to Determine Compliance

- Review of claims list supplied by the surety/self-insured employer/administrator prior to the audit
- Review of claim notes for determination on adjusting authority
- Review of payment ledger

Criteria for a Non-Compliance Finding

- One (1) non-complying event

V. PRELIMINARY ADMINISTRATIVE AUDIT FINDINGS AND FINAL AUDIT REPORT PROCESS

Exit Conference
Once the on site file review has been completed, the auditor will meet, again, with the surety/self-insured employer/third-party claims administrator to review each of the anticipated Preliminary Administrative Audit Findings.

Preliminary Administrative Audit Findings
Audit data is collected, analyzed and evaluated by the auditor and at least one other audit reviewer. Preliminary Administrative Audit Findings, including identification of deficiencies, are prepared. Individual claims may be identified for immediate correction or for follow-up. A formal Preliminary Administrative Audit Findings letter is prepared for the surety or self-insured employer and a copy of the letter is sent to the in-state TPA five (5) business days in advance. A response to the Preliminary Administrative Audit Findings letter is due thirty (30) days after the issuance of the letter to the surety or self-insured employer. The surety/self-insured employer's response must include an action plan addressing each individual finding. The surety/self-insured employer will receive an acknowledgement form with the letter allowing the opportunity to agree or disagree with any or all of the findings.

In lieu of a Preliminary Administrative Audit Findings letter, a show cause hearing may be ordered by the Commission. The show cause order will provide the date, time, and location for the surety or self-insured employer to appear before the Commission. Following a show cause hearing, the Commission may order revocation of the carrier's Check Waiver, requirement to revert to weekly indemnity payments, and/or revocation of carrier's ability to write workers' compensation or to self-insure in the state of Idaho.

Agreement with Preliminary Administrative Audit Findings
Included in the Preliminary Administrative Audit Findings letter will be an acknowledgement form. If the surety or self-insured employer concurs with the findings identified, the surety or self-insured employer must sign the

acknowledgement form and include an action plan for each of the findings indicated in the letter. The action plan should be provided in letter format and include corrective actions to be taken by the surety/self-insured employer/claims administrator to ensure compliance with the laws and rules and prevent a recurrence of the non-complying events.

Disagreement with Preliminary Administrative Audit Findings

If a surety or self-insured employer disagrees with the findings noted in the Preliminary Administrative Audit Findings letter, the surety or self-insured employer must sign the acknowledgement form and provide a detailed letter identifying specific reasons and/or providing examples to support their disagreement with the findings. Once the detailed letter is received, the auditor will review the disputes to render a final determination on the findings.

Closing an Audit

If the surety or self-insured employer concurs with the Preliminary Administrative Audit Findings, a closure letter will be issued affirming the findings and accepting the proposed action plan(s), resulting in closure of the audit.

If, after the auditor reviews the surety or self-insured employer's letter disagreeing with the Preliminary Administrative Audit Findings and determines the findings are still warranted, a letter will be issued affirming the findings resulting in closure of the audit. If the surety or self-insured employer disputes the affirmation of the findings a show cause hearing can be requested.

If a show cause hearing was ordered in lieu of a Preliminary Administrative Audit Findings letter, the audit will remain open pending completion of a probationary period or pending a re-audit.

VI. ACRONYMS

ASW	Average State Wage
AWW	Average Weekly Wage
BDD	Beginning Date of Disability
COS	Change of Status
DOI	Date of Injury
EDI	Electronic Data Interchange
EE	Employee
FROI	First Report of Injury
IIC	Idaho Industrial Commission
LDD	Last Date of Disability
LDW	Last Date Worked
LE	Lower Extremity
LSS	Lump Sum Settlement
MMI	Maximum Medical Improvement
MO	Medical Only
PPD	Permanent Partial Disability
PTD	Permanent Total Disability
RTW	Return to Work
SOP	Summary of Payments
SSN	Social Security Number
TL (TLO)	Time Loss (Open)
TPA	Third-Party Administrator
TPD	Temporary Partial Disability
TTD	Temporary Total Disability
UE	Upper Extremity
WP	Whole Person