ISSUE 4
FALL 2014

Workers' Comp Update

A NEWSLETTER OF THE IDAHO INDUSTRIAL COMMISSION CLAIMS & BENEFITS DEPARTMENT

PAGE 2 AUDITS Summary of Audit Results

PAGE 4 MED FEE NEWS From IIC'S MED FEE ANALYST

PAGE 6 TRU's Tips, Reminders, and Updates

PAGE 8 DECISIONS Supreme Court and IIC decisions

Certified Idaho Workers Compensation Specialist Program (CIWCS)

In 2000, the Claims and Benefits Department began to develop the framework for a workers' compensation certification course that it could offer to claims adjusters and others in the industry – including its own personnel.

While the purpose was to provide guidance to those on the front lines adjusting claims, the process immediately proved invaluable in creating consensus and consistency among the Benefits Analysts who routinely handled over 8,000 phone inquiries each year, primarily from injured workers, but also from adjusters, attorneys, employers, and medical providers. After vetting the coursework internally, a trial course was conducted in 2001. The first production CIWCS course was offered in January of 2002. Since then, the Industrial Commission has presented 56 Workers' Compensation Certification Courses around the state to 1,143 attendees with 725 Idaho Workers' Compensation Specialist Certifications issued as of August of 2014.

We greatly appreciate the partnerships that we have established with both attendees and course co-sponsors, with special gratitude to the several Claims Administrator offices, notably Intermountain Claims, Sedgwick CMS, and Liberty Mutual, who supported this outreach effort right from the start.

We are also pleased to advise that recertification has been simplified. Past attendees will receive correspondence with an option to pay $25 and complete a form certifying that they have read the continually updated materials under the "Claims and Benefits Newsletters and Guidance" section on the Industrial Commission's website. Additionally, recertification can be obtained by attending an upcoming course and paying a minimal $100 to attend, with no test required.

Kudos and Thanks to Industry Members of Benefits Sub-Committees

Thanks to Advisory Committee Claims and Benefits Rules subcommittee members, who volunteered at the Feb 12 Advisory Committee Meeting: Mike Haxby, Gard Skinnner, Darin Monroe, Dan Stephens, Mike McPeek, and Brad Eidam, along with public members Woody Richards and Phil Barber, provided guidance to Commission staff on a package of proposed Benefits Administration rules . This subcommittee met on February 9, March 10, and March 24.

The resultant rule package, encompassing Chapters 4, 6, 8, 10 and 11, was presented at the April 16 Advisory Committee meeting. Subsequently, additional work was done on the definition of "Claims Administrator", to allow conformance with EDI terminology, and that was presented at the August 13 Advisory Committee meeting, without objection. The proposed changes to chapters 4, 6, and 8 were approved at the Commission's Aug 27 Administrative meeting; chapters 10 and 11 will be held over due to technical rules submission issues.

Also thanks to the members of the Claims EDI subcommittee, also formed at the Feb 12 Advisory Committee mtg: Chairman Mike Haxby, Tami Bremer, and Paul Collins MD, along with Commission staff including IT and Benefits personnel, the IC Deputy Attorney General, and the IC Chairman's Law Clerk participated.

This committee met on Feb 13, March 13, and April 9, and also presented its package of EDI-enabling proposed rules at the April 16 Advisory Committee meeting. However, as a result of the inability to finalize some 'incorporated by reference' elements, these rules will be held over for presentation to the 2016 legislature. Thanks to all who helped in the development of these rules.

July 2013 – July 2014 Full Year Summary of Audit Results

Periodic audits are performed to examine claims-handling practices of insurance companies, self-insured's and third party administrators pursuant to IDAPA 17.02.10.051.10. Audits and investigations conducted by the Claims and Benefits Department identify patterns and practices of out-of-state adjusting, unreasonable delays in claims-handling, untimely payment of benefits to injured workers and untimely and inaccurate filing of required reports. Audit variances and results continue to show significant differences between third party administrators. To compare, a site audit of one administrator identified multiple instances of non-prompt, out-of-state adjusting by unauthorized and non-licensed personnel.

This same administrator averaged 14.6 affirmed findings for each surety audited. Another administrator had no instances of non-prompt or out-of-state adjusting and had an average of one affirmed finding for each surety audited.

In order to be deemed timely, a benefit must also be found to be accurately calculated. Hence, on-site audits review for not only timely payment, but also accuracy of benefit payments. In the last sixty days, surety auditors identified $24,417.24 in benefit underpayments which were subsequently paid to claimants. The majority of underpayments were the result of TPD benefit miscalculations, unpaid waiting periods, and PPI payments issued using the whole person per an AMA table rather than "…the exact percentage of the whole man…(i.e., the rating at the closest body part converted mathematically to the "whole man")..

During FY 2014, the Audit Section of the Claims and Benefits Department:

- Completed 30 on-site carrier audits, during which 195 preliminary administrative findings were issued, resulting in the following: 194 affirmed findings, 1 finding was held in abeyance pending a follow-up audit and 0 findings that were withdrawn.
- Completed 24 desk audits, during which 73 administrative findings were issued and affirmed.
-1 Show Cause Hearing was scheduled, resulting in a Commission order withdrawing the subject's check-writing waiver.
-4 Administrative Departmental meetings were held, resulting in 1 voluntary forfeiture of a check-writing waiver, and 3 revocations of authorization to issue indemnity checks bi-weekly.

Top 10 Affirmed Site Audit Findings FY 2013

Surety Site Audit Issue	# Affirmed
Out-of-state adjusting	14
Non-Prompt adjusting	14
Untimely payment of medical benefits	14
CoS incomplete [SSN, proper surety, etc]	14
FROIs do not contain surety and/or in-state claims administrator or mandatory elements [SSN, etc]	13
Adjusting by non-authorized personnel (non-licensed TPA examiners inclusive of NCM)	12
Non-prompt indemnity payments [28 days for initial payment and 7 days for subsequent payments]	11
CoS not sent to claimant	11
EOB/EOR has no local contact information	9
Initial payment copy not sent to IC	9

Forfeiture of Check Writing Waiver / Weekly Issuance of Indemnity Payments

The Commission recently conducted an audit with a surety who acknowledged numerous instances of non-compliance, including out-of-state adjusting, adjusting decisions being made by non-authorized and non-licensed personnel, claims not filed with the Commission, and benefits improperly calculated and untimely paid. The surety agreed to voluntarily forfeit their Check Writing Waiver and revert back to the statutory requirement that indemnity payments be issued on a weekly basis.

Light Duty/Restricted Duty

During audit, we routinely find claimants who have been released to light duty work by the treating physician. Many times the light duty release results in a Change of Status notice being sent to the claimant advising that the claimant has been released to return to work and the "employer is accommodating with no loss in pay." The CoS notice is generated without any supporting documentation from the employer showing that they are actually accommodating the light duty restrictions.

We believe it is reasonable for adjusters to rely on the employer who reports the claimant continues to work within their restrictions and is not suffering a reduction in earnings. However, we believe it would be unreasonable to disregard a claimant in that situation who is reporting that they are not earning the same as they were prior to the injury, though the employer is reporting no loss in earnings. In this situation, the adjuster should obtain a ledger or other documentation of claimant's weekly light duty earnings to measure against claimant's pre-injury average weekly wage and make a proper determination on TPD benefits.

Additionally, in situations where the claimant works a varied schedule and the number of hours worked each week is not consistent it would be difficult to determine if the claimant is being accommodated with no loss in earnings without establishing the claimant's average weekly wage and comparing that to the hours being offered.

We also recommend that the employer make a written offer of light duty outlining the nature of work the claimant is expected to perform. This documentation can be particularly helpful in the event of litigation, and is sometimes asked for during a claim audit. Lastly, we recommend the employer maintain a schedule demonstrating the hours made available to the claimant during the period claimant was released to light duty work, as well as recording the number of hours claimant worked, and documenting any period where work was offered by employer and declined by claimant. Documentation will help alleviate any disputes and protect your employers should a dispute go to hearing.

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Lump Sum Settlement Tips and Hints

Below is a list of helpful tips and hints that will help our team facilitate and expedite the processing of Lump Sum Settlements. Our Benefits Analysts are always available to answer any questions related to the submission of Lump Sum Settlements:

Lump Sum Settlement documents

• Double check all math calculations, ensuring numbers in the settlement document match those same numbers in the exhibit

• Verify the document contains the name of the correct insurance carrier

• Identify the primary claim number when there is more than one claim (bolding is fine)

• Provide all claim numbers in the settlement even if claims have been consolidated in legal

• If two or more sureties are involved provide a breakdown of how much each surety will pay

Claimant's Attorney Memorandum

• Answer ALL questions on the form, particularly Sections IV and V

• Put the gross amount payable in Section III.(A) instead of the net amount payable

• Itemize costs and attach a separate itemization if more convenient

• Provide documentation to support prior fees or costs if possible. Always provide documentation to show why fees are being taken from a PPI balance paid out with a LSS. Examples could include a copy of the letter demanding payment of benefits after non-payment or denial

• Provide a copy of the Retainer Agreement and Disclosure Statement

Defendant's Settlement Summary

• Provide an average weekly wage even if the claim was denied or there was no time-loss paid

• Submit a separate Defendant's Settlement Summary for the primary claim and each secondary time-loss claim

• Address any overpayments or underpayments on Line 4 or Line 5 as applicable

• Line 7 (amount payable) = Line 6 (consideration) + Line 5(b) (underpayment not subsumed) – any overpayment not waived. This calculation needs to be provided for the primary claim only

• Provide all available phone numbers for pro se claimants

• Provide all relevant medical documents related to the claim in chronological order by date of service. Please do not include medical documents unrelated to the claim. Prior conditions, if in question, are routinely addressed in an IME, and do not require individual time-of-service documentation.

NEWS FROM THE MEDICAL FEES ANALYST

Independent Medical Exams

Claimants who are requested by a surety to submit to an Independent Medical Examination shall be reimbursed for loss of wages, if any.

The reimbursement for loss of wages shall be at the current rate of pay if the claimant is working; otherwise, reimbursement will be at the total temporary disability rate.

In addition, claimant may be entitled to reimbursement for travel expenses and subsistence.

Change to Application of 30% Penalty in Medical Fee Disputes

It has long been the practice of Commission staff to dismiss Motions for Approval of Disputed Charges without the application of the thirty percent (30%) penalty when a payment equal to the disputed amount is issued by a payer subsequent to the filing of a provider's Motion.

The Commission recently had occasion to review this practice, and on further consideration has determined that the penalty must be applicable to the underpayment owed at the time the Motion was filed unless the payer submits a Response to the Motion showing its previous payment(s) to be adequate.

A thirty percent (30%) penalty to compensate the provider for having to take these additional measures is provided for in IDAPA 17.02.09.035.10.

Therefore, for all Motions filed on or after October 1, 2014, unless the payer demonstrates, by timely response to the provider's Motion, that the payer's previous payment is adequate, the penalty will now be applied to the underpayment owed at the time the Motion was filed.

Payments issued after the filing of the Motion may be deducted from the ordered amount, but will not reduce the penalty.

Medical Release Authorization Forms

The Commission occasionally receives complaints from claims administrators experiencing difficulty obtaining access to medical records. Generally, under HIPAA, protected health information may not be disclosed without a valid authorization from the patient. However, an exception in HIPAA allows you to disclose information to comply with state workers' compensation laws:

"Standard: Disclosures for workers' compensation. A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault." 45 C.F.R. § 164.512(l). (emphasis added)

Idaho Code Sec 72-432(11) of the Idaho Workers' Compensation Law provides that all medical information bearing on a particular injury or occupational disease shall be provided without liability on the part of the medical provider.

When an authorization is indicated, certain specific information should be included on the signed authorization form to facilitate the prompt release of records.

- Name of patient including date of birth and date of injury.
- Signature of patient and date of authorization.
- Who is authorized to release the information.
- Who is authorized to receive the information.
- Standard HIPAA language to cover records prior to the date of injury.
- Purpose for the disclosure.
- Relationship of requesting party to the patient (i.e., third party claims administrator for Employer/Surety).
- Requested dates of service.
- A statement authorizing release of records for the duration of the claim.

Please note that the specific requested documents should be identified on the signed document rather than an accompanying cover letter.

NOTE: A sample authorization is included in this newsletter (see p. 5).

SEE "PDF" PAGE 5

PDF - CONT'D FROM PAGE 4

Patient Name:_____

Birth Date:_____

Address:_____

Phone Number:_____

SSN or Case Number:_____

(Provider Use Only)
Medical Record Number:_____
□ **Pick up Copies** □ **Fax Copies #**_____
□ **Mail Copies**
ID Confirmed by:_____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____ **to disclose health information as specified:**
Provider Name – must be specific for each provider

To:_____
Insurance Company/Third Party Administrator/Self Insured Employer/ISIF, their attorneys or patient's attorney

_____
Street Address

_____
City **State** **Zip Code**

Purpose or need for data:_____
(e.g. Worker's Compensation Claim)

Information to be disclosed: Date(s) of Hospitalization/Care: _____ **All Dates of Healthcare:** _____

- ❑ **Discharge Summary**
- ❑ **History & Physical Exam**
- ❑ **Consultation Reports**
- ❑ **Operative Reports**
- ❑ **Lab**
- ❑ **Pathology**
- ❑ **Radiology Reports**
- ❑ **Entire Record**
- ❑ **Other: Specify**_____ **Complete Medical Record** _____

I understand that the disclosure may include information relating to (check if applicable):

- ❑ **AIDS or HIV**
- ❑ **Psychiatric or Mental Health Information**
- ❑ **Drug/Alcohol Abuse Information**

I understand that the information to be released may include material that is protected by Federal Law (45 CFR Part 164) and that the information may be subject to redisclosure by the recipient and no longer be protected by the federal regulations. I understand that this authorization may be revoked in writing at any time by notifying the privacy officer, except that revoking the authorization won't apply to information already released in response to this authorization. I understand that the provider will not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. Unless otherwise revoked, this authorization will expire upon resolution of worker's compensation claim. Provider, its employees, officers, copy service contractor, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized by me on this form and as outlined in the Notice of Privacy. My signature below authorizes release of all information specified in this authorization. Any questions that I have regarding disclosure may be directed to the privacy officer of the Provider specified above.

_____
Signature of Patient ***Date***

_____
Signature of Legal Representative & Relationship to Patient/Authority to Act ***Date***

_____
Signature of Witness ***Title*** ***Date***

SAMPLE

TIPS, REMINDERS, AND UPDATES

ASW for 2015

The Average State Wage for the calendar year 2015 has been determined to be $689.00

Non-Economic Damages Cap

The Non-economic damages cap as of July 1, 2014, per Idaho Code Section 6-1603, is calculated to be $324,478.18. The annual history of this cap limit for the past ten years is available on the Commission web site at:
http://www.iic.idaho.gov/index/ba_14_tort_caps.pdf

Common issues when determining AWW

In July 2014, our audit staff began auditing time loss claims for accuracy of benefit calculation and payments during site audits. During our reviews we have identified some common issues seen when calculating an average weekly wage on hourly employees. We hope this list will help our in-state adjusters understand what to include and what not to include when determining an AWW.

- For employees paid by the day or the hour, use the best of the consecutive 13 week periods from the 52 week history
- Include overtime at straight time
- Do not include premium pay such as shift differential and on-call differential
- Always include holiday, vacation, and sick pay
- For employers that pay bi-weekly it is allowable for our administrative purposes to evenly split two of the pay periods so you have four equal 13 week periods

Calling all adjusters

Our Benefit Analysts are here to help answer any questions you may have. We understand that many adjusters handle multiple jurisdictions and sometimes it can be difficult to remember and appropriately apply all of the requirements for each state. We welcome your phone calls and are available to help you with any benefit questions you may have.

Reporting of Required claims documents to the IC via email attachment

The Commission began accepting FROIs, Copies of First Indemnity checks, and copies of Notices of Change of Status via email in 2002. Please note that the attachments are to be sent in Adobe .pdf format only. The Commission will make every effort to open documents in other formats, but failing to do so will result in the document being returned for reformatting. Please also note that our Adjudication Department accepts no email correspondence, nor any documents received as email attachments. Effective December 1, 2014 we will require that a claimant's name be included on the subject line for all claim documents submitted to the IC as email attachments. This is a routine email protocol. Providing this information allows our staff to efficiently search and locate records that have been submitted for processing.

Attorney Fee Guidance

A link to the Kulm decision, which provides guidance on Workers' Compensation Attorney fees, is available on the IC website.
> Attorney Information Page > IDAPA Rules > http://iic.idaho.gov/attorney/kulm_decisions.pdf

Requests for Records

Please take a look at our website. We have added a new Records Request form (RMR 6), to

SEE "TRU" PAGE 7

TRU - CONT'D FROM PAGE 6

TIPS, REMINDERS, AND UPDATES, CONT'D

specifically request records from claims files closed prior to January 1, 2004. The current RMR 4 and RMR 1 will be used to request records subsequent to that date. Because all claims files closed since January 1, 2004 are either maintained on site or are available digitally, those can be produced very quickly. Those files closed prior to that date require accessing microfilm records, which require a great deal more time to produce, and hence are more than twice as expensive. This change will be effective January 1, 2014. Lifetime records searches remain unchanged.

Summary of Payments

Interim Summary of Payments (SOPs) must be filed annually within the first quarter of each calendar year and are required for all death claims and permanent total disability claims. Interim SOPs must include the balance of payments made to the beginning of the current calendar year, payments made during the calendar year, and a total of payments made as of the end of the calendar year being reported. Interim SOPs filed that do not meet the required elements will be returned to the claims administrator for correction. Reporting the total indemnity payments made ensures that the Commission's records agree with the records of the current administrator handling the claim. The SOP for fatal claims may be found on our website at iic.idaho.gov/forms/ic_6f_sop.pdf.

52 week wage period for AWW calculations

For employees paid by the day or by the hour, 72-419(4) requires the 52 week wage period to be taken "immediately preceding" the accident. Our administrative policy allows the adjuster to use the employer's most recent complete pay period immediately preceding the date of the accident or manifestation to commence the computation of the 13 week periods. This eliminates the need for the employer to manually reconstruct artificial pay periods for the claims administrator's use in calculating the average weekly wage.

Settlement forms/Confidentiality

SETTLEMENT FORM Instructions have been updated to remind attorneys that they should not put confidential attorney/client privileged information in those documents. The Claimant's Attorney Memorandum and the Defendant's Settlement Summary forms become part of the official Commission record and could be disclosed later in accordance with provisions of the Idaho Public Records Law, the Judicial Rules of Practice and Procedure or the Idaho Rules of Civil Procedure.

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2015 Annual Seminar on Workers' Comp.

Save the date!

October 29, 2015

Recent/Informative Industrial Commission Decisions

Corgatelli v. Steel West, Inc., Supreme Court of Idaho (Aug. 28, 2014)

In this total and permanent disability case, the Idaho Supreme Court vacated in part the Commission's award of a credit to Steel West, Inc., for previously paid permanent physical impairment benefits to the claimant. The Court held that there is no statutory basis in Idaho's worker's compensation law to credit an employer for permanent physical impairment benefits paid to the claimant before the award of total and permanent disability benefits. In addition, the Court reversed the Commission's finding that the Industrial Special Indemnity Fund (ISIF) was liable for Corgatelli's total and permanent disability benefits. The Court found that the Commission improperly found that the "combines with" prong of ISIF liability was met when both injuries "necessitated" a surgery that resulted in total and permanent disability. The Court held that only a "but for" test satisfies the "combines with" prong of ISIF liability.

Serrano v. Four Seasons Framing, Supreme Court of Idaho (Aug. 25, 2014)

The Supreme Court upheld the Industrial Commission's decision denying claimant additional benefits. The claimant raised a constitutional claim involving his immigration status which was not addressed in the majority decision. In a special concurrence, Justice J. Jones, joined by Justice Burdick, addressed the issue of whether a claimant's status as an undocumented worker bars recovery of permanent disability benefits by quoting Commission Baskin's dissent in Diaz v. Franklin Building Supply.

Beard v. Donahue McNamara Steel, LLC, 2014 IIC 0028 (Apr. 21, 2014)

There were two main issues in this case – whether claimant was employee at the time of the accident and whether the accident occurred arising out of and in the course of employment. Claimant worked for employer from December 2008 until being temporarily laid off on May 22, 2011 after working at the Micron site in Boise. During the time claimant was laid off, he worked for the owner's other company in Ketchum while staying in Arco. After the Ketchum job completed on June 7, 2011, he returned to Arco and intended to return to the Micron site. There was a dispute about when claimant was supposed to return to the Micron site. Before heading back, another owner called claimant and asked him to stop in Burley to pick up some copper wire. There was a dispute as to whether any compensation would be paid to claimant for this. Claimant began drinking and smoking marijuana on the way to Boise and stopped at a bar. Eventually, claimant wrecked between Bliss and Boise due to intoxication. The Commission found claimant was an employee because claimant was "impliedly rehired when he was asked to retrieve and transport welding wire from Burley to Boise." However, citing Morgan v. Columbia Helicopters, Inc. and Reinstein v. McGregor Land & Livestock, the Commission found that claimant's accident did not arise out of or in the course of employment. "Claimant's penchant for drinking and driving and patronizing speakeasies along the way is a departure from the demands of his employment … sufficient to cut off the causal connection."

Kimball v. Gooding County Memorial, 2014 IIC 0043 (June 4, 2014)

At the third hearing on this claim, at issue was whether Claimant was entitled to ongoing medical treatment related to chronic pain and whether Claimant must pay a doctor-charged fee for a 'no-show' at an IME appointment. The first issue had been addressed in previous decisions, so the burden was on the Surety/Employer to show a change in circumstances. Claimant had taken numerous types of prescription pain killers, and the only reason she had changed was the Surety/Employer denied compensability of treatment in 2010. The Referee found and the Commission concurred that the only circumstance that had changed was the standard of care related to short-acting narcotics, and, therefore, any short-acting narcotic after she was cutoff by the treating doctor in 2013 was not compensable. With the second issue, Surety/Employer contends that Claimant should have to pay a fee charged by the doctor for not showing to an IME appointment. Claimant had notice of the appointment, and for whatever reason, failed to show. Assignment of such a fee to the claimant is not in accordance with Idaho Code. Claimant does not have to pay the "no-show" fee. It was noted that § 72-434 provides a sanction to the injured worker who unreasonably fails to submit to an IME. In such cases, claimants are barred from further prosecution of their claims, and suffer suspension of benefits so long as refusal to submit obtains.

Kelly v. Blue Ribbon Linen Supply, Inc. (Sept. 26, 2014)

The sole issue was whether Claimant was entitled to workers' compensation benefits for injuries she sustained while traveling to an IME appointment. The majority held that Kiger v. The Idaho Corp. was controlling and that the automobile accident was not a "compensable consequence," but rather

SEE "DECISIONS" PAGE 9

DECISIONS - CONT'D FROM PAGE 8

"an intervening cause breaking the chain of causation." In his dissent, Commissioner Maynard argued that the threat of losing entitlement of workers' compensation benefits for failing to attend the IME should create "a sufficient nexus to find a requisite causal connection" between the original injury and the car accident.

Morris v. U.S. Bank (Aug. 1, 2014)

The sole issue to be decided was whether Claimant was entitled to TTD benefits from the period of February 1, 2012 through April 16, 2013. Defendants acknowledged that Claimant was in the period of recovery during that time, but claimed she "self-terminated" and there was employment available in the general labor market. In a prior decision from this claim, the Commission found that the job her employer had offered was not suitable for her restrictions. Claimant needed money and continued to work in part because the Surety denied her claim. Defendants argued that the Employer made certain changes, specifically to the work station, to accommodate Claimant. The Commission found, however, that she was unable to perform the job duties with her restrictions, and absent a showing that these duties changed, there was not a reasonable offer of light duty per Maleug. While it was undisputed that claimaint worked, the Commission determined that claimaint's employment was not suitable for her condition. Further, when Claimant applied for jobs, she did not identify her own labor market as there must be a showing of suitable work and a reasonable opportunity to secure under Maleug.

Naveros v. Faulkner Land & Livestock (Oct. 10, 2014)

In 2008, Claimant, a sheepherder participating in a Federal H-2A program, was injured when a horse he was riding reared and fell backward on him resulting in multiple fractures to his lower body. In 2010, because he could no longer work for the employer, Claimant became an undocumented worker. In 2013, Claimant obtained a green card allowing him to legally work in the United States. One of the main issues before the Commission was to what extent Claimant is entitled to PPD. The majority concurred with the Referee's assessment that Brown v. Home Depot required the determination of disability on the date of the hearing. The Referee found, and the majority concurred with, an 80% PPD inclusive of a 12% whole person PPI. In his dissent, Commissioner Baskin felt that Brown did not necessarily mandate reliance on the date of hearing to make a determination of disability as there were significant indications that both parties attempted to manipulate the date of hearing for their own purposes. Commissioner Baskin pointed out that the application of Diaz and Otero in conjunction with Brown could result in a disability anywhere from 0% (while Claimant did not have legal status) to total and permanent disability (immediately following the accident). Commissioner Baskin indicated that he felt the fairest way to determine disability was at the time of the accident.

Skrudland v. Supervalu, Inc., 2014 IIC 0048 (June 9, 2014)

In its Findings of Facts, Conclusions of Law and Order issued March 19, 2014, the Commission found the claimant was entitled to medical benefits and impairment, as well as an award of attorney fees under § 72-804, related to an industrial back injury. The defendant moved for reconsideration on the issue of attorney fees as the defendant claimed that even though the unchallenged doctor's opinion from 2011 proved treatment was related to the industrial injury, evidence provided during the hearing process provided a reasonable basis for denial. The Commission upheld its original order of attorney fees stating "the reasonableness of an adjusting decision can only be based on information known or available at the time the adjusting decision is made." The majority devised a test for manifestation based on the claimaint's knowledge.

Dahlke v. Ash Grove Cement, 2014 IIC 0030 (Apr. 25, 2014)

This deciding issue in this hearing loss case was whether claimant possessed knowledge that his hearing loss was related to his employment. Claimant had worked in an extremely loud work environment for the past 33 years. In his testimony, claimant stated that he "suspected" his hearing loss was work related. However, in his initial recorded statement with the adjuster, claimant stated that he knew for at least ten years his hearing loss was because of his work. The majority found that while claimant stated he "knew", because of the unclear reasoning behind this conclusion (the adjuster did not ask how he knew), there was insufficient evidence to support a finding that manifestation had occured via the route of claimaint's knowledge. The majority devised a test for manifestation based on claimant's knowledge: 1) the person must believe a thing to be true, 2) the person must have justifying reasons for believing it is true, and 3) it must in fact be true. In his dissent, Commission Limbaugh wrote the second factor requiring justification of the belief is onerous on the employer and uncalled for in the statute.

Benefits Photo Op: Fall 2014

Mario Watkins and Chelsea Conlon unveil the new Certification Program class pictures in the IC training room, featuring many class attendees.

Upcoming 2015 CIWCS Courses*

- July 28, 29, 30, and 31, 2015, Blackfoot, co-sponsored by Bingham Memorial Hospital
- November 17, 18, 19, and 20, 2015, Boise, Industrial Commission Main Office

***NOTE:** Cost to attend the Advanced level course will be $249.00, effective May 2015.