



Workers' Comp Update

A NEWSLETTER OF THE IDAHO INDUSTRIAL COMMISSION CLAIMS & BENEFITS DEPARTMENT

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Lump Sum Settlement Processing Update

Over the past twelve months the Commission has made several changes to expedite the time frames in which lump sum settlements are processed. First, the Claims and Benefits Department was tasked to prepare all lump sum settlements including mediated settlements for review and approval within 7 *business* days. In order to achieve this lofty goal, the Commission implemented a new Defendant Settlement Summary template, a new Claimant's Attorney Fee Memorandum template, the same review process for both mediated and non-mediated settlements and the benefits staff began taking all settlements on a first come, first served basis. The new process has been a welcome change for many of our constituents. Recent comments from those in the workers compensation community:

"LSS processing has been very expeditious, all settlements have taken less than 10 business days to process from the time the Commission receives it. I am very pleased."

- Bradford Eidam of Law Office of Bradford S. Eidam

"Average turnaround time in 2014 has been 5 days - pretty good!"

- Emma Wilson of Breen, Veltman, Wilson

"There was a strong consensus from our adjusters that the processing time frame for approvals by the Commission are greatly improved. It appears the changes made on your end have been very effective."

- Mike Haxby, Vice-President Workers' Compensation, Intermountain Claims, Inc.

"The turnaround time has been amazing."

- Darin Monroe of Monroe Law Office

Processing Timelines For Lump Sum Settlements Previous 6 Months *				
Month	Previous Year		Current Year	
	LSS Totals	Avg Days	LSS Totals	Avg Days
Sep	54	19.15	87	6.51
Oct	79	24.74	80	8.65
Nov	73	18.68	80	6.57
Dec	94	21.45	118	8.27
Jan	91	31.91	83	6.51
Feb	95	18.29	87	5.21

* Complete LSS package received at the Industrial Commission

2012 - 2013 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 showed significant differences among third party administrators. To compare, a site audit at one administrator identified 26 violation patterns for the administrator with an average of 13 affirmed findings for each surety audited. Another administrator had no violation patterns with an average of 2 affirmed findings for each surety audited. In 2014, on-site compliance audits are being expanded to also review for accuracy of benefit payments.

During FY 2013, the Audit Section of Claims and Benefits Department:

- » Completed 43 on-site carrier audits, during which 334 preliminary administrative findings were issued, resulting in the following:
 - 262 affirmed findings
 - 52 findings held in abeyance pending a follow up audit with a newly appointed claims administrator
 - 14 advice findings
 - 6 findings that were withdrawn
- » Completed 21 desk audits, during which 38 administrative findings were issued and affirmed
- » 6 Pre-Show Cause Meetings held
- » 1 Show Cause Hearing

The Surety Audit Criteria was updated in February 2014. The link for the most recent Audit Criteria list on the Commission website is: http://iic.idaho.gov/insurancelaudit_criteria.pdf

Top 10 Affirmed Site Audit Findings FY 2013

Surety Site Audit Issue	# Affirmed
EOB/EOR has no local contact info	19
Hard copy documents in claim file not properly date stamped	19
Initial payment copy not sent to Industrial Commission	18
Lack of immediate access to claim files by in-state claims administrator	17
Out-of-state adjusting	16
Claims adjusting correspondence not sent from in-state office	15
CoS not copied to Industrial Commission	13
Non-prompt indemnity payments (28 days for initial payment and 14 days for subsequent payments)	12
CoS incomplete (SSN, proper surety, etc)	12
FROIs do not contain surety and/or in-state claims administrator or mandatory elements (SSN, etc)	11

Deductible Policies

IC§ 72-306A, which was enacted in 1993, allows a deductible contract for worker compensation policies as long as the Director of Department of Insurance approves the contract. The statute outlines approximately 10 standards that must be met for a deductible contract to be approved. Deductibles typically range from \$50,000.00 to \$100,000,000.00 (per occurrence and/or per-year-deductibles) on workers' compensation policies. Recently we have seen instances where a third party administrator has requested additional funding ("self-funding") from an employer before bills and income benefits could be paid. We have also seen instances of employers self-paying for treatment and not reporting claims as required by the standard workers compensation insurance contract. The statute requires a surety to fund all losses and collect the deductible from the policyholder on a quarterly basis rather than wait for loss funding before paying a claim. We will be working closely with the sureties to enforce employer reporting as required by their contract and the Department of Insurance to assure sureties are meeting the loss funding standards required to offer deductible policies.

REMINDERS AND NOTICES

Email Receipt of FROI, CoS, and Initial Payment

The Commission has, for over a decade, accommodated receipt of FROIs, initial payment copies, and notices of Change of Status via email attachment. The specific email addresses are noted on our website at:

http://iic.idaho.gov/insurancelreporting_required_documents_email.pdf

Withdrawal of Check Writing Waiver

A recent Commission order regarding withdrawal of a check-writing waiver is available at:

http://www.iic.idaho.gov/decisions/2014/decisions_2014.html#feb

This came about as a result of a surety 'issuing' checks, but not actually mailing them until several weeks or more had passed.

Update on New Medical Billing Requirements

On April 1, 2014, President Obama signed into law a bill that will delay the adoption of ICD-10 by Centers for Medicare & Medicaid Services (CMS) for one year. All covered entities under the Health Insurance Portability Accountability Act (HIPAA) will be required to transition from the ICD-9 diagnostic coding set to the ICD-10 diagnostic coding set on October 1, 2015. In anticipation of this migration, the Commission adopted a change to the billing requirements found in *IDAPA 17.02.09.035.03(a)*. Whenever possible, providers shall bill using the diagnostic and procedure coding set required by Centers for Medicare & Medicaid Services. All Idaho workers' compensation payers will now have an additional year to take the proper steps to ensure the ability to promptly pay medical bills received from providers with the new ICD-10 diagnostic and procedure coding sets. Further information regarding *ICD-10* may be obtained from the *Centers for Medicare & Medicaid Services*, or by contacting Patti Vaughn at the Industrial Commission, (208) 334-6084.

Explanation of Benefits (EOBs)

Explanation of Benefits are considered claims correspondence and are required to be mailed from within the state of Idaho. However, if a surety has an approved Check Waiver on file with the Commission then an EOB may be sent from outside the state as long as the check for payment is **included** with the EOB.

Contacting Pro Se on Lump Sum Settlements

In response to an inquiry at the adjusters meeting at the Commission in December, 2013, attendees were advised that, in regard to mediated settlements submitted for pro se claimants, Commission Claims and Benefits personnel may contact the pro se. Such contact may be required to clarify issues of possible subrogation, outstanding medical bills, and loans.

Summary of Payments

1. A Summary of Payment is required on wages in lieu claims, provided the days of wages-in-lieu exceeds the five day waiting period.
2. All Summary of Payments should reflect the actual benefits paid to the claimant. The IC audit process will determine what was due for each period of disability and will be reconciled with what was actually paid. Any overpayment of benefits should be reflected in the 'Amount Paid' column rather than just noted on the form.

Forecasting Permanent Impairment Ratings

An impairment rating may not be forecast or predicated upon declined treatment or surgery. §72-422 defines permanent impairment as "any anatomic or functional abnormality or loss after maximal medical rehabilitation has been achieved and which abnormality or loss, medically, is considered stable or nonprogressive at the time of evaluation." If the injured worker is MMI because he or she refused further treatment, the impairment must be on the current functional abnormality or loss.

Is Subrogation an Adjusting Decision?

Surety subrogation analysts may be located out of state. A subrogation analyst should not directly make contact with a claimant nor should they be involved in negotiating the compromise of the lien. Direct contact with a claimant or involvement in decisions affecting a claimant's benefits could be considered out-of-state adjusting.

Medical Case Management

Nurses involved in medical case management are not required to register with the Commission. We do monitor medical case management to ensure, in instances of telephonic case management, nurses are calling from states that are members of the Nurse Licensure Compact. A list of the states that participate in the Compact can be found at: <https://www.ncsbn.org/nlc.htm>. Nurse case managers cannot make adjusting decisions unless they are also an in-state Idaho licensed claims adjuster. Also, a nurse case manager cannot enter the exam room unless they have permission from both the doctor and claimant.

Recent/Informative Industrial Commission Decisions

Page v. McCain Foods, Idaho State Supreme Court

In its third appearance at the Idaho State Supreme Court, at issue was attorney fees and whether Claimant's Counsel could take a 30% fee on the fees awarded under §72-804. The Court held that the Commission has discretion over attorney fees, a fee agreement does not guarantee a certain percentage award, and fees awarded under §72-804 are not a "benefit" subject to fees.

Vawter v. UPS, Inc., Idaho State Supreme Court

Claimant was a truck driver for UPS. After clocking in at the airport loading site, Claimant sat down and bent over to tie his boots. Claimant felt a pop and was eventually diagnosed with a herniated disc and early cauda equina symptoms. Claimant received two back surgeries. Surety denied the claim based on the contention the accident did not arise out of his employment. The claim went to hearing and the Commission ruled the injury was compensable, TTD is due from the date of accident until claimant was declared MMI, Claimant is due medical expenses in the amount of \$149,033.68, and Claimant is not entitled to an award of attorney fees. UPS then filed a complaint against ISIF to establish ISIF's liability. Claimant had suffered a low back injury in 1990 and received a 0% PPI rating. The Surety had not challenged this PPI rating until it was attempting to establish ISIF liability. The Commission ruled the Surety was estopped from arguing a different PPI rating. Surety filed a Motion for Reconsideration, which it affirmed its finding of quasi-estoppel, but found collateral estoppels barred Claimant from the issue of raising his entitlement to \$24,627.80 to an additional medical expenses incurred prior to the hearing. The Supreme Court addressed the issues as follows: 1) The Claimant's injury is compensable under the positional risk doctrine from *Mayo v. Safeway Stores*, and even then, because he was required to have his shoes tied, "the task [resulting in injury] is assuredly connected to his employment."; 2) The Commission properly applied the doctrine quasi-estoppel as "one cannot blow both hot and cold."; 3) The Commission improperly applied the doctrine of collateral estoppel to prevent Claimant from asking for additional money to pay past medicals as the request was not a "separate cause of action" subject to the doctrine; and 4) The Commission properly denied an award of attorney fees. The decision of the Commission was affirmed in part and reversed in part.

Schell v. Payless Shoe Store, Industrial Commission Decision

Claimant was a manager at the shoe store and, on 9/19/2009, was reaching and felt a pop. Claimant was diagnosed with a herniated disc at L4-L5. Claimant began receiving physical therapy at the recommendation of her treating physician, Dr. Weight, but saw little improvement. In an IME, Dr. Walker opined Claimant would be at MMI with two weeks of work-hardening or aggressive physical therapy. Dr. Weight agreed with the recommendation. Surety did not inform Claimant of the recommendation, nor did it authorize the physical therapy. Surety allowed Claimant to continue treatment, but then on 3/24/2010, sent a COS to Claimant stating PT was only authorized through 1/29/2010. Because the denial occurred after the fact, and because of the lack of contrary medical evidence, attorney fees were awarded on Surety's unreasonable denial of the physical therapy.

Snider v. Empro Employer Solutions, LLC, Industrial Commission Decision

Claimant worked at Bruneel Tire and its sister company, Pro Tech, which utilized Empro to process its payroll and workers' comp coverage of its employees. Claimant was basically the "number two" man at Bruneel Tire behind Mr. Bruneel, but continued to assist with the moving of tires on a daily basis. Claimant received a total of six surgeries related to his upper extremities, all of which were paid by Employer/Surety, but continued to complain of symptoms. Both treating doctor, Louis Murdock, MD, and IME doctor, Kevin Krafft, MD, declared Claimant medically stable in the Fall of 2012. In January of 2013, Dr. Murdock referred to Claimant's status as "medically stationary at this moment; however, ... he must be examined every three to four months." Even though the treating doctor stated Claimant was currently medically stable, Referee found that Claimant's industrial injury is not medically stable due to the further statements in the doctor's opinion.

Deon v. H&J, Inc., Order on Reconsideration

The issue of collateral estoppel was brought before the Commission after it sua sponte moved for reconsideration.

DECISION

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Claimant suffered an accident in 2007. In 2011, Claimant filed a complaint against Employer/Surety and later filed a complaint against ISIF. ISIF and Claimant agreed to a lump sum settlement, and a hearing between employer and claimant occurred. In the settlement with ISIF, those parties agreed ISIF liability existed as prior injury and current injury combined to create total perm. The LSS apportioned Carey liability at 60/40, where ISIF was responsible for 60% of the total perm. The decision of the hearing between Claimant and Employer came out later, with the Referee finding the Employer solely responsible for the total perm condition. The Commission adopted the Referee's findings of fact and conclusions of law, but then moved sua sponte to reconsider the issue of collateral estoppel. The Commission ruled in its Order that the Claimant was estopped from arguing a different position from the LSS, and applied Carey to the impairments of record, which apportioned 23% of total perm responsibility to Employer.

New Change of Status Memo Posted

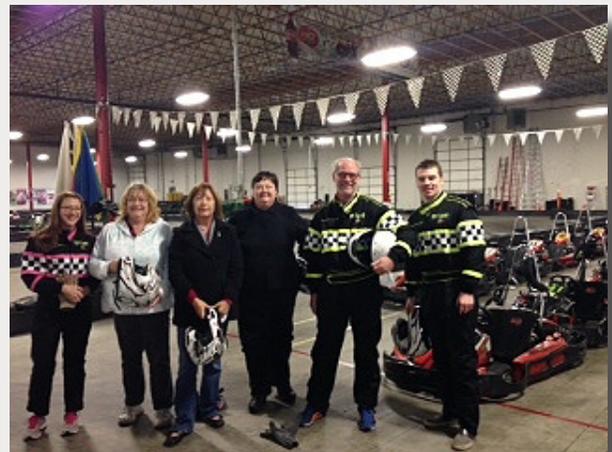
At the periodic adjusters' meeting held at the Commission offices on December 10, 2013, the issue was raised about the Commission's reliance on the Dempewolf decision (Dempewolf v. T&H Investments, Memorandum Decision and Order on Reconsideration, IC 89-668421), referenced in the memorandum posted on the Commission web site, revised 5-07-13, regarding Change of Status notices. The concern was raised that the "penalty" meted out by Dempewolf was not based on statute. The Commission agrees. That referenced memorandum is replaced effective 2-10-2014 by the memorandum located at:

www.iic.idaho.gov/insurance/notice_of_change_status_guidance.pdf

Taken in context with the Commission advice that the acceptance of a claim, including a medical only claim, constitutes a change of status, we will note that, since medicals remain open forever on compensable claims (absent an approved settlement), we do not expect to see a Change of Status notice advising of the closure of a medical only claim.

CLAIMS AND BENEFITS DEPARTMENT

The Claims and Benefits Department celebrated the holidays by racing in the First Annual Salad Dressing 500. Mario, Faith, and Matt finished the race in that order, with Scott probably still circling around the track.



Above: The Cobras (from left to right) Chelsea, Arlene, Barb, Melissa, Scott, Blake



Above: The Mongoose Posse (from left to right) Jeanne, Matt, Mario, Kelci, Faith, Kim