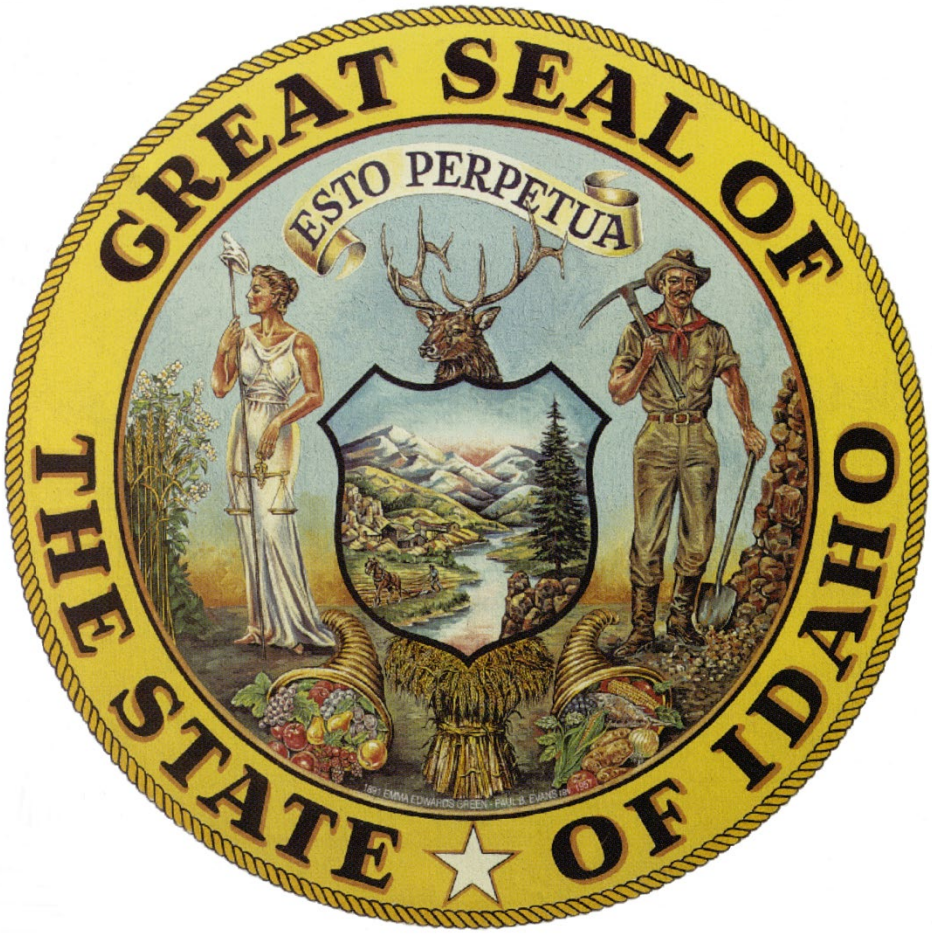
Idaho Industrial Commission
Audit Guidelines



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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.

THESE GUIDELINES ARE NOT NEW LAW, BUT ARE AN AGENCY INTERPRETATION OF EXISTING LAW.

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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 settlement agreements with claimants; and provide, at the insurance carrier's expense, necessary forms to any worker who wishes to file a claim under the Worker's Compensation Law.
Sources: **I.C. §72-305** and **IDAPA 17.01.01.305.01**

Adjuster – An individual who adjusts workers' compensation claims. Source: **IDAPA 17.01.01.010.01**

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 Worker's 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 Worker's Compensation Law. Source: **IDAPA 17.01.01.010.11**

Claims Administrator – An organization, including insurers, third-party administrators, independent adjusters, or self-insured employers, that service workers' compensation claims. Source: **IDAPA 17.01.01.010.10**

Claims Services – Aspects of claims handling to include but not limited to reserve setting, three-point contacts, accident investigations, acceptance or denial of claims, authorization of medical treatment, authorization and triggering of the issuance of medical and income benefit payments. Medical fee schedule adjustments and release of authorized benefit payments may be considered ministerial or administrative functions.

Closure – For time-loss claims, closure means that the file will be administratively retired following an audit by the Commission.

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 3.1 – The IAIABC authored EDI claims release 3.1 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 or the worker has a statutory impairment award per the schedule. Source: **IDAPA 17.01.01.010.24**

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 17.01.01.010.26**

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

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

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 17.01.01.010.31**

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

Notice – Actual notice or, where required, written notice of an event.

Payor – The legal entity responsible for paying benefits under the Idaho Worker's 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.

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. 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 settlement agreement (SA), the termination of disability shall occur on the date the SA 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 17.01.01.010.38**

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 17.01.01.010.39**

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

II. OVERVIEW OF AUDIT PROCESS

The responsibility and regulatory accountability for compliance with the Idaho Worker's 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 1, Chapter 1.

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
- Full 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 a full 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 a full audit.

A full 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 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
- Annual Reports on file or filed timely with the Commission
- Proper notification of in-state signatories/adjusters
- Notice of initial payments sent to the Commission
- Final Reports filed with the Commission within 30 Days of surety or self-insured employer claim closure
- Required information provided on First Report of Injury filings
- Proper date stamping of documents in claim files
- 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 or claims administrator 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 determination whether the Initial Payment was timely filed is measured by using the information provided to the Industrial Commission through EDI transactions.

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 unless the claim is in litigation. Non-litigated claim files with attorney involvement are subject to review; however, specific communications between the insurer/TPA and their counsel may be subject to the attorney-client privilege. ***During every full audit, all total permanent disability claims and fatality claims may be audited to ensure annual reports have been filed and benefits have been paid correctly.***

Full Audit Process

The Commission will provide an initial notice of the audit to the insurer not less than four (4) weeks prior to the audit start date, 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 or need remote read-only access to the claims system, and identify the information required to be provided to the auditor(s) prior to and/or at the time of the audit start date. 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
- 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 may 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. An insurer/TPA found to be noncompliant will be allowed a period of twelve (12) months from the closing of an audit to bring adjusting practices into compliance before a follow-up audit will be initiated.

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 17.01.01.305

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; authorize all compensation benefits due; accept service of claims, applications for hearings, orders of the Commission, and all processes which may be issued under the Worker's Compensation Law; enter into compensation agreements and settlement agreements with Claimants; and provide at the insurance carrier's expense necessary forms to any worker who wishes to file a claim under the Worker's 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, and ***Appendix E***: Payment of Benefits Under Deductible Policies Guidance Memorandum.

Criteria Used to Determine Compliance

- Review of adjuster claim notes for determinations on 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. Checks Issued Out-of-State Without An Approved Waiver IDAPA 17.01.01.305.06; IDAPA 17.01.01.305.09

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. Lack of Immediate Access to Claim Files by In-State Claims Administrator IDAPA 17.01.01.305.02

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

Criteria to qualify for a Non-Compliance Finding

- One (1) non-complying event

4. Non-Prompt Response to Commission Inquiries Regarding Claim Status
IDAPA 17.01.01.302.01.e; IDAPA 17.01.01.302.02.e; IDAPA 17.01.01.601.08; IDAPA 17.01.01.602.03

In the event the Commission requests additional information when auditing the Final Reports, 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. Failure to timely respond may trigger a full audit.

Criteria Used to Determine Compliance

- Surety response to Commission inquiry on a claim file or request for additional information for approval of a Final Report

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 17.01.01.305.11

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 payments 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 payments 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 17.01.01.801.01; IDAPA 17.01.01.801.03

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.

Criteria Used to Determine Compliance

- Review of claim notes and medical reports 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 trigger events 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 trigger events 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
IDAPA 17.01.01.302.01.c.i

Each authorized insurance carrier shall notify the Commission in writing of any change to the primary claims administrator within fifteen (15) days of such change and report the designated claims administrator for every insured Idaho employer through POC.

Criteria Used to Determine Compliance

- Review of notifications on file at the Commission
- Review of POC filing

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 manifestation of an occupational disease requiring treatment by a physician or resulting in absence from work for one (1) day or more. For audit purposes, the First Report of Injury is due not later than ten (10) days from the date the claims administrator learns that the injured worker needs treatment.

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 17.01.01.305.01.a

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
- Untimely response to Commission inquiries

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; IDAPA17.01.01.305.03

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 17.01.01.305.11.a

An initial decision to accept or deny a claim for an injury or manifestation of an 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, ***see Appendix I****:* Prompt Claims Servicing Guidance Memorandum.

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 17.01.01.305.11; IDAPA 17.01.01.803.06

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, ***see Appendix J:*** 30% Penalty on Medical Fee Disputes.

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 medical payments 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 medical payments 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 17.01.01.803.06.e.iii

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. <u>Annual Reports not on file or filed untimely at the Commission</u>
IDAPA 17.01.01.602.01

All fatal claims and permanent total disability claims require Annual Reports (SROI ANs) to be filed 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. <u>Untimely Notification of In-State Signatories/Adjusters</u>
I.C. §72-305; IDAPA 17.01.01.305.01.c

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. <u>Initial Payment Notice not sent to the Commission</u>
IDAPA 17.01.01.305.10

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 notice of the first check showing the date it was issued, shall be sent to the Industrial Commission electronically the same day with a SROI IP filing.

Criteria Used to Determine Compliance

- Review of EDI Transactions filed with the Commission.

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.

17. Change of Status Notice not sent or sent untimely to the Commission I.C. §72-806; IDAPA 17.01.01.601.02; IDAPA 17.01.01.801.05

The party giving notice pursuant to I.C. §72-806 shall send a copy of any such notice to the Industrial Commission, the employer, or the worker's attorney if the worker is represented, at the same time notice is sent to the worker. Notice shall be sent to the Commission in accordance with the Commission's rule on electronic submission of documents.

Criteria Used to Determine Compliance

- Review of Change of Status notices issued in the claim file
- Review of EDI Transactions filed with the Commission

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.

18. Final Reports Not Filed with the Commission Within 30 Days from Claim Closure
IDAPA 17.01.01.602.01

The Final Report (SROI FN) shall be filed for indemnity claims, death claims, permanent total disability claims or any claims resolved by settlement agreement within thirty (30) days from the date the surety or self-insured employer closes the claim file.

Criteria Used to Determine Compliance

- Review of claims closed during the audit period to identify the surety or self-insured employer's closure date and filing of the Final Report 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.

19. Documents in Claim File not Properly Date Stamped
IDAPA 17.01.01.305.04

Each of the documents listed in Subsections 305.02 [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 305.03 [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. A date stamp on the first page of several related documents may suffice provided the attached documents remain attached to the first page.

Criteria Used to Determine Compliance

- Review of claim file documents pursuant to Subsections 305.02 and 305.03 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.

20. 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 17.01.01.305.11; IDAPA 17.01.01.401; IDAPA 17.01.01.402

Payment for settlement agreement, 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, ***see Appendix H:*** Conversion of Permanent Partial Impairment to Whole Person.

Criteria Used to Determine Compliance

- Review of AWW calculations
- Review of TTD calculations
- Review of TPD calculations
- Review of PPD calculations
- Review of timely settlement agreement payment
- Review of death benefit determination and payments

Criteria for a Non-Compliance Finding

- One (1) non-complying event

21. Improper Recovery of Voluntary Payments

I.C. §72-316; I.C § 72-806; IDAPA17.01.01.801.05

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 Guidance Memorandum.

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

22. <u>Employers with Deductible Policies are Paying Benefits Directly and/or Adjusting Out of State</u>
I.C. § 72-301; I.C. § 72-306A; I.C. § 72-319; IDAPA 17.01.01.305.01

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 Guidance Memorandum.

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

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
An acknowledgement form will be included in the Preliminary Administrative Audit Findings letter. 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
MMI	Maximum Medical Improvement
MO	Medical Only
POC	Proof of Coverage
PPD	Permanent Partial Disability
PTD	Permanent Total Disability
RTW	Return to Work
SA	Settlement Agreement
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

APPENDIX A: Criteria to Qualify as a Finding of Non Compliance

	Audit issue	% or Number of Events to Qualify [if the Surety has NOT been audited within the previous 24 months]	% or Number of Events to Qualify [if the Surety has been audited within the previous 24 months]	Actual Events Found
1	Authorized Adjusting Personnel Violations	1	1	
2	Checks issued out-of-state without an approved Waiver	1	1	
3	Lack of immediate access to claim files by in-state claims administrator	1	1	
4	Non-prompt response to IC inquiries regarding claim status	1	1	
5	Non-prompt indemnity payments [28 days for initial payment and 7 days for subsequent payments]	5%	3%	
6	CoS not sent or sent untimely to claimant	5%	3%	
7	Untimely notice to IC of changes in in-state claims administrator for a covered employer	1	1	
8	FROIs not of record at IC	2%	1%	
9	Insufficient in-state personnel to promptly adjust claims	1	1	
10	Claims adjusting correspondence not authorized from in-state office	1	1	
11	Non-prompt adjusting	10%	8%	
12	Untimely medical payments	15%	10%	
13	EOB/EOR has no local contact info	1	1	
14	Annual Report not on file at IC	1	1	
15	Untimely notification of in-state signatories/adjusters	1	1	
16	FROIs not sent to IC within 10 days of receipt by surety or claims administrator	5%	3%	
17	Initial payment copy not sent to IC	10%	5%	
18	CoS not sent or sent untimely to IC	10%	5%	
19	Final Report not filed with IC within 30 days of claim closure	12%	10%	
20	Hard copy documents in claim file not properly date stamped	10%	5%	
21	Failure to pay benefits in accordance with Statute and Rule	1	1	
22	Improper Recovery of Voluntary Payments	1	1	
23	Employers with Deductible Policies are paying benefits directly and/or adjusting out of state	1	1	

Audit criteria are used as a guideline. Auditors reserve the right to issue a finding for any one individual non-compliance issue, or as may be required for short term re-audits.

Revised 06/05/2024

APPENDIX B

IDAHO INDUSTRIAL COMMISSION SURETY CLAIMS FULL AUDIT

SURETY PROCEDURES QUESTIONNAIRE

Please complete prior to audit start date. Attach additional pages if more space is required for responses.

1. **Workers Compensation Law, Rules, and Manuals**	**Yes**	**No**
Is training provided to all Claims Examiners to summarize and explain any changes to the Worker's Compensation Law and IDAPA Rules each year, and to review pertinent IC and Supreme Court decisions?		

2. **Licensing for Third-Party Adjusters**	**Yes**	**No**
Are all authorized signatories licensed?		
Are all licenses current?		

3. **Document Handling**	**Yes**	**No**
Is all incoming mail date stamped by all offices handling such mail (i.e. the local adjusting office; a call-in center; a bill-review vendor; an imaging center, etc.).		
Does the stamp identify the Adjusting Company, Office, and date?		
Is mail given to each Claims Examiner on the day it is received?		
Is all Original claims correspondence authorized from the in-state office?		

4. **Telephone Calls from Claimants**	**Yes**	**No**
Are all claimant inquiries handled in-state?		
Do you have a toll-free telephone number to the Idaho in-state office for claimants to use who live outside your calling area?		

5. **Inquiry Handling**	**Yes**	**No**
Are inquiries responded to in a timely manner?		
Is there a back-up Claims Examiner for each claim?		
If there is a back-up examiner, does that examiner have the authority and the capability of adjusting the claim without waiting for the regular examiner to return to work?		
Does a supervisor verify that telephone calls/inquiries are responded to in a timely manner?		

6. **Change-of-Status Notices**	**Yes**	**No**
Are notices sent out on a timely basis?		
Are notices filed electronically with the Industrial Commission?		
Are notices sent in all appropriate instances, i.e.: change of benefit rate, beginning benefits, ending benefits, change of benefit type, denial, reversal of denial, acceptance, claim closure, etc.		
Are claim acceptance notices sent out on both medical only and indemnity claims?		

7. **Benefit Checks**	**Yes**	**No**
Are checks signed in the local office?		
Are checks mailed from local office?		
If an urgent payment is needed, do you have the ability to issue payment within 24-hours?		

8. **Authorized signatories on surety documents**	**Yes**	**No**
In the past twelve months, has your office added/lost personnel who are/were authorized to make claims decisions for the subject surety?		
If 'Yes', was the Commission notified in writing of this change?		

9. **Time-Loss Claims**	**Yes**	**No**
Are requests made to physicians for PPI ratings in all instances of surgery, or where the physician has listed restrictions?		
In the request for PPI, are restrictions and an opinion on the likelihood of future medical care also requested?		
Are multiple PPI ratings averaged?		

10. **Medical-Only Claims**	**Yes**	**No**
Are checks to providers mailed promptly as billed?		
Do you instruct providers to send bills and notes to your local office?		

11. **Fatality and Total Perm Claims**	**Yes**	**No**
Are annual reports sent to Industrial Commission during the first quarter of each year on fatalities and total perms?		
Are you aware an Affidavit of Due Diligence is to accompany requests for an IC Order regarding fatalities for whom no dependents have been located?		

12. **Denied Claim Handling**	**Yes**	**No**
Are denial letters sent to claimant and filed electronically with the Industrial Commission?		
Does your denial letter provide specific reason(s) for the denial?		
If denial is for lack of medical causality, do you always have in hand the supporting medical opinion prior to issuing the denial?		
If the Employer sends the claimant to a designated provider, and the claim is subsequently denied, will you pay for that medical visit?		
Is medical treatment ever denied because the need for that treatment has been apportioned between the work injury and a pre-existing condition that is not part of another work comp claim?		
Do you deny claims based on non-receipt of a medical release form signed by the claimant, sometimes labeled as "non-cooperation"?		
Are denials made within 30 days of receipt of the claim?		

13. **Reserves**	**Yes**	**No**
Is the reserve-setting authority of each in-state examiner commensurate with their authority to approve medical and indemnity benefits?		
What is the reserve authority for your adjusters? Medical Only: _____ Time-Loss: _____		
Do reserves above a certain level require approval by a person outside of Idaho? If Yes, Name & Phone: _____		
Have reserves ever been insufficient to pay obligations already due?		

14. **Final Reports**		
Are Final Reports filed electronically with the Commission within 30 days of closure?		

15. **Medical Fee Review**	**Yes**	**No**
Does the review vendor always review according to the Idaho Fee Schedule, when such is applicable?		
Does the EOB/EOR provide the local address and phone number?		

16. **Travel Expense Reimbursement**	**Yes**	**No**
Does your office anticipate travel expenses and automatically send a reimbursement form to the claimant?		

Reviewed and completed by:

_____ _____

Printed Name Surety/Adjuster/Self-Insured Company name

_____ _____

Signature Date

APPENDIX C
IDAHO RULES AUDIT QUESTIONNAIRE

IDAPA Rules Audit - State of Idaho Industrial Commission

Surety:_____ TPA (if applicable):_____

1) Adjustors License obtained, Idaho Department of Insurance *(for TPAs only)*
   Cite: IDAPA 17.01.01.305.01 (attach additional pages as necessary)
   Name:_____ Date obtained:_____ Date Expires:_____

2) Files must be maintained within the state or immediately accessible.
   Cite: IDAPA 17.01.01.305.02 Are all files maintained within the state? _____

3) Checks must be signed and issued in the state, unless a waiver has been requested and granted.
   Cite: IDAPA 17.01.01.305.09
   Do you have a waiver?_____ (If yes, please attach a copy.)
   If not, are all checks issued in-state?_____
   Do you offer electronic payments in lieu of a check?
   If so, what method?

4) Notice of first indemnity checks must be filed electronically with the IC.
   Cite: IDAPA 17.01.01.305.10 Does your company comply? _____

5) TTD and PPI checks must be issued weekly
   Cite: IDAPA 17.01.01.305.11 Does your company comply? _____
   (Note: bi-weekly for income and monthly for PPI allowed if not objected to by claimant)
   If they are not issued promptly, the Commission may order that an immediate payment, convertible to cash that day at a local bank, be made to claimant. Could your company comply? _____
   How:

6) Copies of all checks must be maintained in the in-state files or immediately reproducible.
   Cite: IDAPA 17.01.01.305.10
   Are copies of all compensation checks available in the in-state files? _____

7) Claims must be adjusted in-state.
   Cite: IDAPA 17.01.01.305.01
   Are all of your claims adjusted in-state? _____.
   Are all medical fee decisions made in-state on a visit-by-visit basis? _____
   Are all compensation decisions made in-state by an authorized adjuster? _____

8) The offices shall be staffed by adequate personnel to conduct business.
   Cite: IDAPA 17.01.01.305.01
   Does your office have adequate staff to promptly reply to inquiries, promptly make adjusting decisions, and promptly make payments due? _____
   What is your average ratio of Time Loss claims to FTEs over the past twelve months? _____
   What is that ratio currently? _____

9) Within fifteen (15) days of any change of status, the claimant shall be notified and an electronic filing is made to the IC.
   Cite: Idaho Code § 72-806 and IDAPA 17.01.01.801.05.
   Are notices sent to claimant within fifteen days, and copied the same day to the IC? _____.

10) The Commission shall be notified in writing within fifteen days of any change of resident adjuster.
   Cite: IDAPA 17.01.01.302.01.c.i
   TPAs: Has the Commission been timely advised of your authority for this surety?_____
   Please attach a copy of the letter of authority.

Printed name: _____ Signature:_____
Title: _____ Date: _____

Appendix D
In-State Adjusting Requirements Guidance Memorandum

IDAHO INDUSTRIAL COMMISSION
PO Box 83720
Boise, ID 83720-0041
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1-800-950-2110

COMMISSIONERS
Thomas E. Limbaugh, Chairman
Thomas P. Baskin
Aaron White

BRAD LITTLE, GOVERNOR

George Gutierrez, Director

February 15, 2023

RE: In-State Adjusting Requirements

In November 2001, October 2009, May 2013, and June 2020, the Industrial Commission provided to all in-state adjusters a letter of advice, pointing out certain requirements for adjusters in the State of Idaho. Of particular emphasis were provisions requiring that adjusting decisions be made by in-state claims examiners.

In February 2023, the Idaho Legislature introduced legislation proposing removal of certain language from Idaho Code 72-305 interpreted to mean that each surety shall maintain "brick and mortar" offices located within the state. Given that some claim administrators have long been handling claims in Idaho exclusively from the residences of their employees located within the state of Idaho, the Commission believes some clarification is in order.

The following list, although not exclusive, illustrates areas of ongoing concern:

1. All aspects of handling and adjusting workers' compensation claims, including investigation and interviews, must be conducted by an Idaho licensed in-state adjuster or by an in-house in-state adjuster. In-state adjusters must have full decision-making authority, including but not limited to, acceptance or denial of claims, authorization of medical treatment, and payment of income benefits. Requiring the use of a toll-free number reaching an out-of-state individual to resolve issues involving any aspect of the handling of a claim is prohibited.

2. Neither Idaho Code 72-305 nor IDAPA 17.01.01.305 require that the in-state "office" or "offices" from which Idaho claims are adjusted must be a non-residential "brick and mortar" structure from which adjusters collectively work. The in-state adjusting requirement of statute and rule is satisfied where an insurance carrier, or third-party administrator, employs Idaho resident adjusters who work from home to service Idaho claims. Each claims adjuster, whether employed directly by the surety or working as a licensed, resident adjuster, must report to the Commission the physical location within the state of Idaho where claims handling will occur. In the case of a home office, the adjuster's private residential address need not be disclosed to the public; however, a valid in-state address shall be provided where service of legal documents may be accomplished.

3. Decisions on the medical management of workers' compensation claims must be made by the insurer through its in-state licensed adjuster or by an in-house in-state adjuster, and not by a case management nurse, whether they are inside or outside the state. This does not preclude adjusters from consulting with healthcare specialists or nurse case managers.

4. Written communication from medical providers and others involved in a claim and all forms and reports required by law or rule must be distributed through the in-state adjuster.

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Thomas E. Limbaugh, Chairman
Thomas P. Baskin
Aaron White

BRAD LITTLE, GOVERNOR

George Gutierrez, Director

5. All benefit checks must be signed and issued by the in-state adjuster unless the insurer has applied for and received an approved written waiver from the Industrial Commission allowing checks to be written out-of-state. A waiver allowing issuance of checks from an out-of-state source does not confer authority to adjust or handle any aspect of a workers' compensation claim from an out-of-state location. The waiver pertains to check issuance only.

6. If a waiver is granted for the issuance of benefits checks from a location outside the state of Idaho, the in-state adjuster must retain full authority and ability to do the following:

a. Obtain instant access to the current electronic or computer payment history and records and the ability to reproduce such records in its in-state office;

b. Complete the data input that results in the issuance of a benefit check.

7. "Fronting" will not be permitted. This includes but is not limited to the practice of maintaining an in-state adjuster who does not have full authority to make decisions regarding the acceptance or denial of claims, full authority over medical treatment and payment, and full authority to sign and issue checks, absent an approved waiver.

8. The worker must receive Change of Status notices within fifteen (15) days of the effective date of the change, copied immediately to the Commission, and, when applicable, a copy of the medical report that is the basis for the change must be attached to claimant's copy of the notice.

Complete information regarding the claims adjusting requirements for Idaho is available on the internet at the following site: www.iic.idaho.gov. There are links on this site to the Industrial Commission's Administrative Rules and to the Idaho Workers' Compensation Law.

The above is not new law, but is an agency interpretation of existing law. Further questions can be directed to:

Kayla Pollard, Audit Program Analyst
Kayla.Pollard@iic.idaho.gov
(208) 334-6061

Matt Johnson, Audit Program Analyst
Matt.Johnson@iic.idaho.gov
(208) 334-6003

We appreciate your cooperation and attention to these matters as we all strive to maintain the integrity of Idaho's excellent workers' compensation system.

Thomas E. Limbaugh
Chairman

Thomas P. Baskin
Commissioner

Aaron White
Commissioner

Appendix E
Payment of Benefits under Deductible Policies Memorandum

IDAHO INDUSTRIAL COMMISSION

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Thomas P. Baskin, Chairman
Aaron White
Thomas E. Limbaugh

BRAD LITTLE, GOVERNOR

Mindy Montgomery, Director

June 10, 2020

RE: Payment of Benefits under Deductible Policies

The purpose of this memorandum is to remind stakeholders of the requirements of Idaho Workers' Compensation law relating to deductible policies.

Idaho Code § 72-306A, enacted in 1993, requires, *inter alia*, that a surety initially fund all losses and then seek reimbursement for such losses paid, up to the amount of the stated deductible, from the policyholder.

The Commission has discovered instances of self-funding, in which a surety's TPA was required to request funding from an employer before medical bills and income benefits could be paid. The Commission has seen instances where employers made direct payments for medical bills that are incurred, both with and without the knowledge of their insurance carrier.

Therefore, some employers and insurers evidently believe that IC § 72-306A authorizes an employer to make direct payments on claims under the deductible amount. However, the statute does not contemplate direct payment of benefits by employer; payment of benefits must emanate from surety, or from surety *via* its TPA.

Second, the Commission finds it necessary to reiterate that all adjusting decisions must be made by the designated Idaho in-state claims adjuster. All aspects of handling and adjusting workers' compensation claims, including investigation and interviews, must be conducted by an Idaho licensed in-state adjuster or by the surety's in-house, in-state adjuster. In-state adjusters must have full decision-making authority, including, but not limited to, acceptance or denial of claims, authorization of medical treatment, reserve setting, and payment of income benefits. Employers may not require an adjuster to obtain prior authorization from the employer to resolve issues involving any aspect of the handling of a claim. This activity is prohibited. The adjusting of a claim is exclusively the province of the surety, or its designated in-state TPA.

If you are aware of any direct payments made by an employer for claims, or the employer making or finalizing adjusting decisions, you are advised to immediately notify the employer to cease this practice. Failure to comply with these legal requirements by the employer or insurance carrier may result in violation of IC § 72-301, IC § 72-306A, IC § 72-319 or IDAPA 17.01.01.305.01. Violations may result in a penalty or sanctions as determined by the Idaho Industrial Commission, up to and including withdrawal of authority to write workers' compensation coverage in Idaho, or referred to the Department of Insurance for further action.

The above is not new law, but is an agency interpretation of existing law. Further questions can be directed to:

Kayla Pollard
(208) 334-6061
Kayla.Pollard@iic.idaho.gov

Matt Johnson
(208) 334-6003
Matt.Johnson@iic.idaho.gov

Thomas P. Baskin, Chairman

Aaron White, Commissioner

Thomas E. Limbaugh, Commissioner

11321 W. Chinden Blvd., Boise, ID 83714
Equal Opportunity Employer

Appendix F
Notice of Change of Status Guidance Memorandum

IDAHO INDUSTRIAL COMMISSION

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COMMISSIONERS
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Aaron White
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BRAD LITTLE, GOVERNOR

Mindy Montgomery, Director

June 10, 2020

RE: Notice of Change of Status

The purpose of this memorandum is to clarify the Idaho Industrial Commission's policy regarding notice of Change of Status. This memorandum replaces the information presented in the "Notice of Change of Status Guidance Memorandum" revised 5-07-13.

Idaho Code § 72-806 provides "A workman shall receive written notice within fifteen (15) days of any change of status or condition, including, but not limited to, the denial, reduction or cessation of medical and/or monetary compensation benefits, which directly or indirectly affects the level of compensation benefits to which he might presently or ultimately be entitled." IDAPA 17.01.01.801 applies this requirement to sureties and employers, specifies the form of the notice, and requires a copy be sent to the Commission.

Idaho Code § 72-604 states "When an employer … willfully fails or refuses to file … the notice of change of status required by section 72-806, Idaho Code, the limitations prescribed in § 72-701 and § 72-706, Idaho Code, shall not run against the claim of any person seeking compensation until such report or notice shall have been filed."

We understand this to mean that the failure to provide notice of any change in status which directly or indirectly affects the payment of income or medical benefits will subject the surety to the consequences described in § 72-604, Idaho Code.

Further, we advise that we do not consider attachment of any medical opinion to be required for the notice copy sent to the Commission.

The above is not new law, but is an agency interpretation of existing law. Further questions can be directed to:

Kayla Pollard
(208) 334-6061
Kayla.Pollard@iic.idaho.gov

Matt Johnson
(208) 334-6003
Matt.Johnson@iic.idaho.gov

Thomas P. Baskin, Chairman

Aaron White, Commissioner

Thomas E. Limbaugh, Commissioner

Appendix G
Procedure for Recovery of Overpayments Memorandum

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COMMISSIONERS
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Aaron White
Thomas E. Limbaugh

BRAD LITTLE, GOVERNOR

Mindy Montgomery, Director

June 10, 2020

RE: Procedure for Recovery of Overpayments

This notice serves to describe the process by which Employer / Surety may recover voluntary payments made to Claimant which are determined to be in excess of what was rightfully owed. Idaho Code § 72-316 allows such payments, subject to the approval of the Commission, to be deducted from the amount yet owing, provided, however, that the deduction is made by shortening the duration of weekly income payments, rather than by reducing the amount of weekly income payments.

In order to apply an overpayment as a credit against an amount yet due, Surety must seek the Commission's prior approval [see *Melendez v. Con Agra Foods/Lamb Weston,* 2015 IIC 0038 (2015)]. Prior approval must be requested by the simultaneous submission of a Notice of Change of Status to Claimant, in accordance with Idaho Code 72-806, and to the Commission in accordance with IDAPA 17.01.01.801.05. Such request will be deemed approved by Benefits Department staff as a purely ministerial function but subject to subsequent review.

This recovery process necessitates that the Notice of Change of Status requesting prior approval must continue to be submitted to the Commission on paper even after the implementation of EDI Claims Release 3.0 on November 4, 2017. Prior approval requests may be submitted either through US Mail or as an electronically scanned document sent via email to changeofstatus@iic.idaho.gov. Further details will be included in the Idaho EDI Claims Release 3.0 Implementation Guide.

In the event that an overpayment is determined on a claim where no further income benefits are currently due, Employer / Surety will have no statutory basis from which to recover the overpayment and may not exercise any collection actions against the Claimant under another court's jurisdiction.

The above is not new law, but is an agency interpretation of existing law. Further questions can be directed to:

Kayla Pollard
(208) 334-6061
Kayla.Pollard@iic.idaho.gov

Matt Johnson
(208) 334-6003
Matt.Johnson@iic.idaho.gov

Thomas P. Baskin, Chairman

Aaron White, Commissioner

Thomas E. Limbaugh, Commissioner

Appendix H
Conversion of Permanent Partial Impairment to Whole Person Memorandum

IDAHO INDUSTRIAL COMMISSION

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BRAD LITTLE, GOVERNOR

Mindy Montgomery, Director

June 10, 2020

RE: Conversion of Permanent Partial Impairment to Whole Person

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The purpose of this memorandum is to clarify how administrative staff of the Idaho Industrial Commission will apply the conversion of single rating of body part to whole person, under IDAPA 17.01.01.402.

The AMA Guides to the Evaluation of Permanent Impairment contains tables for converting body part ratings to whole person, but they are not mathematically accurate. The Guides do not result in a conversion to the exact percentage, and in some cases can skew the benefits drastically. For example, a 90% PPI of the great toe would result in about 38 weeks of benefits. If converted to whole person, (4%), only 20 weeks of benefits will be paid. Claimant loses 18 weeks of benefits. Or, a 25% little finger PPI converted to a 2% whole person PPI would increase benefits from 3.5 weeks to 10 weeks. (See examples attached). Obviously, it is not an exact conversion and does not comply with IDAPA 17.01.01.402. It is important to use the exact conversion so that a party cannot attempt to manipulate the amount of benefits paid by applying the AMA Guides.

After considering IDAPA 17.01.01.402, the administrative policy of the Idaho Industrial Commission shall be as follows:

1. When a body part is rated for impairment by a physician, the body part closest to the injury will be used to determine benefits, even if the physician has also rated an additional level, or the whole person.

2. If the worker sustains two injuries, one of which is listed in the statutory schedules (Idaho Code § 72-426 & § 72-428), the ratings will not be combined using the AMA Guides. The statutory benefit will be paid, and the remaining benefit will be calculated to the exact percentage.

The above is not new law, but is an agency interpretation of existing law. Further questions can be directed to:

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Thomas P. Baskin, Chairman

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Appendix I
Prompt Claims Servicing Memorandum

IDAHO INDUSTRIAL COMMISSION

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June 10, 2020

RE: Prompt Claims Servicing

This letter offers guidance on the Commission's expectations for prompt claims servicing. The below is not new law, but is an agency interpretation of existing law.

The prompt claims servicing rules were crafted to reconcile the need to investigate a claim with the statutory requirement of Idaho Code §72-402 that income benefits be issued within twenty-eight (28) days of the date of disability. During an audit, the claims administrator's compliance is measured by the timely acceptance or denial of the claim, i.e., within thirty (30) days of receiving knowledge of the claim. However, the employer's failure to timely report claims to its claims administrator does not excuse the employer/surety from its obligation for the prompt payment of benefits as clearly stated in the rule:

Prompt Claim Servicing. Prompt claim servicing includes, but is not limited to:

> a. Making an initial decision to accept or deny a claim for an injury or occupational disease within thirty (30) days after the claims administrator receives knowledge of the same. The worker shall be given notice of that initial decision in accordance with Section 72-806, Idaho Code. Nothing in this rule shall be construed as amending the requirement to start payment of income benefits no later than four (4) weeks or twenty-eight (28) days from the date of disability under the provisions of Section 72-402, Idaho Code.

Unless a denial is issued within twenty-eight (28) days of the date of disability, income benefits must be started per IC §72-402. The deadline for issuance of income benefits may arrive before the claims administrator's thirty (30) days to determine compensability has expired. The investigation may continue beyond the thirty (30) day deadline as long as voluntary payments are made while the determination to accept or deny the claim is made.

It is expected that compensability for most claims will be promptly determined in accordance with the timeframes in the rule, and that claims requiring a prolonged investigation are the exception. These standards will be enforced in the context of surety audits for all claims filed on or after March 28, 2018. For further information, please refer to the Commission's Audit Guidelines available on our website at https://iic.idaho.gov/benefits-administration/insurance-information/.

Further questions can be directed to:

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Appendix J
Prompt Claims Servicing Memorandum

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June 10, 2020

RE: 30% Penalty on Medical Fee Disputes

It was once 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 was issued by a payer subsequent to the filing of a provider's Motion. The Commission had occasion to review this practice, and 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.

When a payer fails to pay the acceptable charge upon receipt of the provider's bill, and again upon receipt of the provider's written appeal, the provider is forced to file a Motion for Approval of Disputed Charge with the Commission. The provider is also required to copy all pertinent documents supporting its fee dispute, fill out multiple forms, and send these documents to both the Commission and the payer. A thirty percent (30%) penalty to compensate the provider for having to take these additional measures is provided for in IDAPA 17.01.01.803.06.i:

> *"…If Provider's motion disputing CPT or MS-DRG coded items prevails, Payor shall pay the amount found by the Commission to be owed, plus an additional thirty percent (30%) of that amount to compensate Provider for costs and expenses associated with using the dispute resolution process…"*

When a payment is issued after the Motion is filed, the provider is not compensated for the additional costs and expenses. 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 is 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.

As always, claims administrators may avoid the penalty by prompt payments or a credible, timely defense of their payments.

We thank you for your diligence in ensuring that prompt and accurate payments are issued to medical providers. The above is not new law, but is an agency interpretation of existing law. Further questions may be directed to:

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