

Legislative Update



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INTRODUCTION

The legislature was extremely busy in the Workers' Compensation area in 2010. Unfortunately, none of the legislative changes are designed to favor insurance carriers, self-insureds or employers. The following summarizes the new legislation, and, if appropriate, offers our opinion of the bill.

HOUSE BILL 1009 – CONCERNING PINNACOL ASSURANCE (effective date July 1, 2010)

House Bill 1009 requires the Pinnacol Assurance board post the date, time, and location of each board meeting on the Pinnacol Assurance website at least 7 days prior to the scheduled meeting.

HOUSE BILL 1038 – THE BROCHURE (effective date July 1, 2010)

House Bill 1038 requires all employers and insurance carriers provide to injured workers a brochure developed by the Director that describes the claims process and informs the Claimant of his or her rights.

HOUSE BILL 1109 – COVERAGE FOR INMATES

WORKING FOR A PROGRAM CERTIFIED BY THE FEDERAL PRISON INDUSTRIAL ENHANCEMENT CERTIFICATION PROGRAM (effective date August 11, 2010)

House Bill 1109 adds to the definition of "employee" all inmates of a Department of Corrections facility or jail who work or participate in a training, rehabilitation, or work release program certified by the Federal Prison Industry Enhancement Certification Program. Please note that the employer is not the State, City or County that owns the jail, but the company and/or organization that runs the certified program.

HOUSE BILL 1247 – WORKERS' COMPENSATION CLASSIFICATION APPEALS BOARD

House Bill 1247 extends the Workers' Compensation Classification Appeals Board through July 1, 2021.

SENATE BILL 11 – CONCERNING MEASURES TO REDUCE CONFLICTS OF INTEREST IN WORKERS' COMPENSATION CASES (effective date July 1, 2010)

Senate Bill 11 places additional obligations on physicians who wish to be

considered eligible to perform DIMEs. It appears these measures affect physicians associated with Respondents far more than they affect physicians associated with Claimants.

Senate Bill 11 mandates that the director adopt rules requiring physicians to disclose information pertaining to that physician's business, financial, employment, or advisory relationship between a vested physician or any entity affiliated with the physician and the insurer, self-insured employer, or Claimant who is a party to the claim. Such information is to be disclosed in a "summarized format." Any physician who fails to disclose the requested summarized information cannot perform as a DIME physician until he or she complies. Senate Bill 11 allows any party to request and obtain and review this summary disclosure prior to striking a physician from the DIME panel list. A party will not be required to make a strike of a physician from the list until he or she has received and has had a reasonable opportunity to review the summary disclosure.

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Senate Bill 11 requires that any insurer, self-insured employer, or healthcare provider, or an employer contractor of any of these, shall not pay or receive any form of financial remuneration that is based on the following:

- The number of days to maximum medical improvement.
- Rate of claims approval or denial.
- The number of medical procedures, diagnostic procedures or treatment of appointments approved.
- Any other criteria designed or intended to encourage a violation of the Workers' Compensation Act.

If an insurer, carrier, self-insured employer, or healthcare provider makes a prohibited payment, they are considered in violation of Part 11 of Article 3 of Title 10, and such person shall be subject to penalties pursuant to these provisions. In addition, the Director can fine each violation pursuant to Section 8-83-304(1.5).

Senate Bill 11 does not restrict or limit the ability of a claims adjuster or employee or contracted claims personnel to investigate, detect, or prevent fraud or limit the payment or receipt of financial incentives for any other lawful purpose.

Senate Bill 11 prohibits a treating physician from communicating with the

employer or insurer of an injured worker regarding that injured worker unless the injured worker is present for the communication or the treating physician makes an accurate written record of the communication containing all relevant and material information that was communicated and provides the injured worker access to the writing in the same manner as medical records disclosed or as required by Director rules. In other words, if an adjuster wants to speak with a physician, the treating physician must make an accurate written record and send a copy of the record to the parties.

SENATE BILL 12 – DOUBLING PENALTIES

Senate Bill 12 is probably one of the most significant pieces of legislation that passed this year. Senate Bill 12 doubles the maximum penalty per day from \$500 a day to \$1,000 a day. Senate Bill 12 provides Claimant and Claimant's counsel with additional incentives to pursue penalties. Specifically, Senate Bill 12 allows an Administrative Law Judge to apportion, in whole or in part, the penalty award between the aggrieved party and the Workers' Compensation cash fund, except that the amount apportioned to the aggrieved party cannot be less than 50%.

By raising the stakes for

penalties, Claimant's attorneys most likely will be more aggressive in seeking penalties against carriers and employers. The question that remains is whether administrative law judges are going to interpret Senate Bill 12 as a mandate to double the size of penalties. The administrative law judge still has the discretion to award anything less than \$1,000 a day, including one cent per day.

Senate Bill 12 changes Section 8-43-401(2)(a). That section currently requires that if a carrier or self-insured employer does not pay medical benefits within 30 days of the date that they were due, the carrier or self-insured employer will be penalized 8% of the amount wrongfully withheld, provided that the Claimant prove that the insurer or self-insured employer "willfully" delayed payment of these benefits. Senate Bill 12 changes "willful" to "knowingly." This change makes it easier for Claimant's to obtain penalties under this section. Now, Claimants need only prove that a claim adjuster knew that he or she failed to timely pay medical benefits and no longer need to prove that the adjuster intended to not timely pay medical benefits.

The penalty changes take effect beginning August 11, 2010 for "conduct

occurring on or after" August 11, 2010.

SENATE BILL 13 – ACCOUNTABILITY FOR WORKERS' COMPENSATION INSURERS (effective date July 1, 2010)

Senate Bill 13 requires carriers perform a survey of a Claimant at the close of each claim. The survey will be prescribed as to form and manner by the Director. Basically, this is a customer service survey to allow Claimant's to indicate whether they believe that they were properly serviced during their claim.

Senate Bill 13 requires the CEO of Pinnacol Assurance to submit an annual report to the governor as well as to various legislative committees on the business operations, resources, and liabilities of Pinnacol Assurance.

Finally, Senate Bill 13 mandates that the Director is required to clearly post on the Divisions' website the procedure for an injured worker to follow to file a complaint with the Division regarding any issue that could conceivably result in a penalty situation.

SENATE BILL 112 – CONCERNING RATE SETTING FOR WORKERS' COMPENSATION INSURANCE (effective date January 1, 2011)

Senate Bill 112 amends Section 8-44-111. At this time, for purposes of experience modification,

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medical only claims shall be calculated in the same manner as claims with indemnity payments. Senate Bill 112 also requires that the insurance commissioner make available to the public information concerning a rate filing submitted by a rating organization including the aggregate loss and payroll data by class code that the rating organization submits with a rating file.

SENATE BILL 163 – CONCERNING WORKERS’ COMPENSATION PROCEDURES (retroactive application)

Last year, the legislature passed laws that required physicians that perform IMEs for Respondents to digitally record those IMEs. Following its passage, an issue arose as to whether the recording provisions were prospective (for new claims filed after August 2009), or retroactive (for all pending claims). Senate Bill 163 clarifies that the recording requirements are mandated for all claims, not just new claims.

Senate Bill 163 mandates the director review mortality tables from the United States government and private industry and issue rules establishing a single life expectancy table beginning July 1, 2010, and continuing in every even numbered year. As you know, especially in settlement of permanent total disability claims, the

parties sometime disagree as to what life expectancy table to use. Obviously, the longer a Claimant's life expectancy, the higher the present value computation. Having said that, it is our experience that most parties, both Claimant and Respondent, use the life expectancy table on the Division of Workers' Compensation website to calculate present value.

Senate Bill 163 requires Respondents to pay settlement amounts within 15 calendar days after the date the executed settlement order is received by Respondents.

Finally, Senate Bill 163 states the following:

All documents that are required to be exchanged under Article 40 through 47 of this Title shall be transmitted or served in the same manner or by the same means by all required recipients.

Basically, this means that if a claims adjuster receives a medical report (for example), and wants to provide a copy of that report to Respondents' attorney and Claimant's attorney, the adjuster cannot fax the medical report to the Respondents' counsel and mail the report to Claimant's counsel. The adjuster needs to either fax

the report to both parties, mail the report to both parties, e-mail the report to both parties, etc.

SENATE BILL 178 – CONCERNING FAIRNESS IN WORKERS' COMPENSATION HEALTHCARE PROVIDER REVIEW PROCESSES (effective date July 1, 2010)

Senate Bill 178 creates the "Provider Review and Disclosure Act." In the legislative declaration of this Senate Bill, the general assembly determined that insurer performance programs are used in marketing, sales, and other reports, and therefore, may impact an employer's selection of an authorized healthcare provider. Consequently, to avoid improper profiling, these performance programs must be fair, objective, consistently applied, and accord providers due process. Consequently the general assembly found that requiring minimal standards and full disclosure of performance program data and methodologies will help improve the quality and efficiency of healthcare delivered to injured workers.

Performance programs are defined as any program, system, or process in which an insurer rates or recognizes the cost, efficiency, quality, or other assessment or measurement of a provider's care that is disclosed to patients, other healthcare

providers, employers, or the public.

Senate Bill 178 mandates that all performance programs include, at the minimum, certain criteria, including:

- A quality of care component.
- Clear representation of the weight given to the quality of care component, which weight shall be equal to or greater than any other factor.
- If a performance program includes an employer satisfaction element, a patient satisfaction element must also be included and the patient satisfaction element shall be weighed equal to or greater than the employer satisfaction element.
- If claims data is used, the claims data must be accurate and appropriately attributed to the provider.

Performance program results must be reported to each healthcare provider reviewed in the program and must include comparison of the provider's results and the results of other providers. If a particular provider does not agree with the results in any performance program, that provider is given appeals rights to challenge the results.

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Senate Bill 178 also provides that at least 30 days before implementing any new or amended performance program, an insurer must file a detailed description of the performance program with the Director.

Finally, any violation of the Provider Review and Disclosure Act is deemed a deceptive act or practices in the business of insurance, subjecting the insurer to penalties.

SENATE BILL 187 – CONCERNING WORKERS’ COMPENSATION

Senate Bill 187 results in eight changes to the Workers’ Compensation Act, none of which appear favorable to Respondents.

Medicaid Exclusion

Senate Bill 187 states that Medicaid and other indigent healthcare programs are not health insurance plans that should be considered for purposes of determining average weekly wage. The current state of the law is that when an injured worker loses employer covered health insurance, the replacement cost of any new health insurance plan is included in Claimant’s average weekly wage. In most cases, Medicaid and other indigent healthcare programs do not cost anything; therefore, there is no replacement cost. Consequently, if a Claimant receives an increase in average weekly wage

based on the replacement cost of health insurance, then loses that insurance and goes on Medicaid, Respondents must continue to maintain Claimant at the increased average weekly wage.

Maintenance Care

Senate Bill 187 fundamentally changes who has to incur the cost of litigation when maintenance care is challenged. Senate Bill 187 states that if any party files an Application for Hearing on maintenance care recommended by an authorized treating physician that is unpaid and contested and then maintenance care is either admitted fewer than 20 days before the hearing or is ordered by a judge after the Application for Hearing is filed, the administrative law judge must award the Claimant all reasonable costs incurred in pursuing maintenance care, excluding attorneys fees.

In most cases, this provision will be applied in situations in which a Final Admission of Liability is filed and Respondents do not admit for maintenance care despite the authorized treating physician’s recommendation. Claimant files an Application for Hearing and either wins at hearing or Respondents admit 20 days or less prior to hearing. Typically, these costs will involve the cost of any physician retained by Claimant to render an

opinion as to maintenance care.

This provision also applies in situations where Respondents want to challenge ongoing maintenance care previously awarded by Final Admission of Liability or by Order. For example, Claimant received maintenance care for ongoing back problems. The authorized treating physician renders the opinion that a recent onset of Claimant’s hip problems is related to the low back claim and provides the following treatment recommendations:

- Sacroiliac injections
- Medical marijuana
- Chiropractic care

After obtaining a second opinion from another physician, Respondents deny maintenance care and take the position that treatment for Claimant’s hip problems are not related to his low back claim. After hearing, an administrative law judge determines that the hip problems are related to the low back claim but only awards Claimant treatment in the form of sacroiliac injections (the ALJ specifically declines to award medical marijuana and chiropractic care). Although Respondents can argue that, overall, it prevailed at hearing because most of the treatment was denied, Claimant can argue that because the judge

awarded sacroiliac injections, Respondents are required to pay for Claimant’s court costs.

Average Weekly Wage

Section 187 specifically defines the phrase, “at the time of the injury” as used in the average weekly wage section, to refer to the date that a Claimant’s accident actually occurred. Having said that, Senate Bill 187 also makes clear that an Administrative Law Judge continues to have discretion to fairly determine a workers’ average weekly wage.

Assisted and/or Employer Paid Disability Benefits no Longer Offset Against PPD

Senate Bill 187 eliminates Respondents ability to offset Claimant’s PPD against an award of Social Security disability benefits or an award of disability benefits under an employer pension or disability plan. In other words, the only time that Social Security disability or an employer funded disability benefit is offsettable is under the circumstances when Claimant is receiving temporary disability benefits or permanent total disability benefits.

Claimant’s Rejection of Modified Employment

Senate Bill 187 enumerates situations in which a Claimant’s

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ongoing entitlement to temporary disability benefits will not be terminated for failure to accept an offer of modified employment. These conditions include the following:

- The offer of modified employment would require Claimant to travel a distance of greater than 50 miles one way more than Claimant's pre-injury commute.

- An ALJ determines that the Claimant's rejection of the offer of modified employment was reasonable considering the totality of the circumstances including accounting for:

- The consequences of the industrial injury.
- The financial hardship that would be imposed on Claimant in order to accept the offer of modified employment.
- Any other reason that would, in the opinion of the ALJ, make it impractical for the claimant to accept the offer of modified employment.

Senate Bill 187 states that the above-outlined circumstances are not exhaustive. As a result, an administrative law judge has total discretion to make a determination as to whether Claimant is justified in not accepting an offer of modified employment.

Please note that the statutory provisions allowing Respondents to terminate Claimant's temporary disability benefits because of failure to accept offered

employment, still stands. Consequently, Senate Bill 187 does not prevent Respondents from continuing to send offers of modified employment to Claimant and terminating those benefits if Claimant does not accept the modified employment. These new statutory provisions are triggered only after Claimant either fails to accept modified employment, resigns his position, or is terminated from his position.

Elimination of the Loss of an Eye by Enucleation as a Scheduled Disability

Senate Bill 187 eliminates the loss of an eye by enucleation as a scheduled disability. In the future, when an individual loses an eye by enucleation, Claimant will be entitled to a whole person rating. The legislature replaced loss of an eye by enucleation with loss of a tooth. Please note that if someone loses a tooth because of a work related injury, they get six weeks of a scheduled disability.

Adjustment to the Caps

Currently, a Claimant who is awarded 25% whole person impairment rating or less is subject to the \$75,000 cap of combined temporary and permanent partial disability benefits. A Claimant whose impairment rating exceeds 25% whole person rating is subject to the \$150,000 cap. Senate Bill 187 states that, effective for injuries after January 1, 2010, the level of

these caps will be increased on a yearly basis, based on the percentage increase in the state's average weekly wage. For example, if, on July 1, 2012, the director determines that the state average weekly wage increased by 5%, the caps will also increase by 5%.

Lump Sums

Senate Bill 187 provides that neither the director nor an administrative law judge shall in any way attempt to condition the lump sum that a Claimant may receive by requiring the Claimant to waive his right to pursue permanent total disability benefits before receiving the lump sum amount.

Effective Dates

Except for the statutory provisions as it pertains to awarding costs for the challenge of maintenance care and for the adjustment to the caps, all other provisions of Section 187 are effective as of July 1, 2010.

CONCLUSION

Short of the legislature passing fundamental reform in terms of how disability benefits are paid, the bills addressed above will have a far reaching effect on how Respondents and designated authorized

treating physicians will practice in the area of Workers' Compensation. Taken as a whole, these legislative changes have the propensity of having a chilling effect on authorized treating physicians in their attempt to provide care to injured workers. This new legislation will also, to a certain amount, cause a chilling effect on physicians who are willing to perform independent medical evaluations for Respondents. Finally, these legislative changes, particularly the doubling of the maximum amount of penalties, will have a chilling effect on how claim adjusters do their work. These legislative changes will create a new and potentially treacherous environment for all Respondents. This office stands ready to guide our clients through these new legislative changes. Consequently, if you have any particular questions on how these legislative changes may impact any of your ongoing claims, please feel free to call any of the Workers' Compensation attorneys in this office.

This office has copies of all the legislative bills passed in 2010. If you would like copies of these bills, please contact us, and we will immediately provide them to you.

RESOURCES

DCWYB&E:

<http://www.dnvrllaw.com>

Colorado Division of Labor:

www.coworkforce.com

Office of Administrative Courts:

<http://www.colorado.gov/dpa/oac/>

Colorado Legislature:

www.leg.state.co.us/

Benefits Calculator:

<http://www.coworkforce.com/benefits/>

Centers for Medicare and Medicaid Services:

<http://www.cms.hhs.gov/>

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The members of DCWYB&E have been practicing in the areas of Workers' Compensation Defense, Subrogation, Insurance Defense, Employment Law, and Commercial Litigation for over 19 years.

The firm currently employs 10 attorneys, 5 paralegals, and 1 office administrator. The firm is essentially a litigation boutique specializing in all types of insurance litigation, employment and securities work. In its early years, the firm concentrated solely on Workers' Compensation defense. Three of the six Shareholders continue to concentrate in the Workers' Compensation arena. However, four of the Shareholders specialize in all areas of insurance, employment, and commercial litigation.

The attorneys and Shareholders in the Firm have significant trial, hearing and arbitration experience. And, although we are zealous advocates, we pride ourselves on evaluating matters with an eye toward economics and of course the well being of the insured and the effect a matter will have on the reputation and foundation of the company remains a primary focus.

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