DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation
7 CCR 1101-3
WORKERS' COMPENSATION RULES OF PROCEDURE

Rule 4 Carrier Compliance

4-1 COMPLIANCE AUDITS

(A) Every insurer shall submit to compliance audits of its claims by the Division of Workers' Compensation. The purpose of compliance audits is to examine whether claims are adjusted in accordance with the Workers' Compensation Act and the Workers' Compensation Rules of Procedure. Compliance audits are a method for the Division to regulate and oversee the Workers' Compensation System. A compliance audit conducted pursuant to this Rule 4 is intended to be an autonomous process.

(1) Identifying and underlying claim information examined as part of a compliance audit is accessible only to the insurer under review and shall not otherwise be open to any person except upon order of the Director. If the Director issues an order in a specific claim the order will be sent to all parties.

(2) Division personnel shall give advance written notice of the compliance audit to the insurer and provide an initial list of claims to be audited. If additional information is requested for the compliance audit, it must be provided. Unless the Division determines that circumstances warrant otherwise, the insurer will be given at least 15 calendar days notice.

(3) The insurer shall make the claims selected for the compliance audit and any requested information, including training and procedure manuals, available to the auditor at the time and place designated by the auditor. If the audit requires out-of-state travel by the auditor, the insurer may be required to pay travel costs.

(4) Failure to make claims and/or information requested by the auditor available to the auditor for audit shall be considered willful refusal to comply with Division efforts.

(5) The insurer shall indicate the dates of its receipt on all documents it files with the Division as well as on all medical bills and reports. For those documents required to be exchanged, the insurer shall indicate on the face of the documents or by some other verifiable method, the date the documents were mailed or delivered and to whom they were mailed or delivered.

(B) A compliance level will be determined for each category examined during the audit. A compliance level is the ratio of deficiencies found within a category in relation to the total number of applicable audit inquiries reviewed in that category. A deficiency is a failure to comply with statute or rule. The categories to be examined during the compliance audit may include but are not limited to the following:

(1) Reporting of claims.
(2) Initial positions on liability.
(3) Timeliness of compensation payments.
(4) Accuracy of compensation payments.
(5) Medical benefit payments.
(6) Termination of temporary disability benefits.
(7) Final Admissions.
(8) Average Weekly Wage.
(9) Waiting period.
(10) Document exchange.

(C) For the categories listed in subparagraphs 1 through 7 in paragraph (B) of this Rule 4-1, fines will be imposed for the repeated failure to demonstrate satisfactory compliance. A compliance level of 90% or higher is considered satisfactory compliance. No fine will be imposed for deficiencies in any category in which satisfactory compliance is determined in the compliance audit. For the categories listed in subparagraphs 8 through 10 in paragraph (B) of this Rule 4-1, the auditor will comment upon the insurer's adjusting practices but fines will not be imposed for deficiencies found on compliance audits in those categories.

(D) After reviewing the insurer's procedures and examining the claims selected for audit and other information requested, the auditor will provide the insurer with preliminary audit findings, including compliance levels. Thereafter:

(1) The insurer will have thirty (30) calendar days within which to agree in writing with the preliminary audit findings. If the insurer does not agree with the preliminary audit findings it shall, within the same 30 calendar days, state with particularity and in writing to the auditor its reasons for all disagreements and provide therewith in writing all relevant legal authority, and/or other relevant proof upon which it relies in support of its position(s) concerning its disagreements with the preliminary findings.

An extension of time not to exceed 30 additional days may be granted to the insurer to submit its written reasons for disagreement and to provide the authority and/or proof upon which it relies as is required by this rule by filing a written request for such extension of time with the auditor prior to the expiration of the 30 calendar days afforded to the insurer to agree with the preliminary findings. Any disagreement not so submitted to the auditor within the 30 day period or within such additional time as was granted in response to the insurer's written request for an extension of time is waived.

(2) The auditor, the auditor's manager and the insurer shall have twenty (20) calendar days after submission of the written disagreement with the preliminary audit findings within which to resolve those disagreements and to agree to the preliminary audit findings.

(3) If the auditor, the auditor's manager, and the insurer are unable to agree on the preliminary findings within the 20 day period afforded in paragraph (D)(2) of this Rule 4-1, the preliminary audit findings along with the insurer's written disagreements will be referred to the Director for the Director's determination regarding the audit findings. The final determination of the relevance and/or weight given to any authority or proof submitted in connection with the insurer's disagreements regarding audit findings is reserved to the Director.

(4) When a determination regarding audit findings has been made by the Director, the Director will thereafter cause the Final Audit Report to be prepared and/or order such other action as the Director may determine warranted.

(5) When the insurer has agreed to the preliminary audit findings without disagreement, or when the insurer fails to disagree therewith in the manner provided in this Rule 4-1(D) or, when the insurer agrees to the preliminary findings before the time for referral to the Director under Rule 4-1(D)(4) has occurred, or when the Director has made a determination regarding audit findings as provided in paragraph (D) of this Rule 4-1, the Final Audit Report will issue. The Final Audit Report will contain a summary of the final audit findings, comments on the insurer's adjusting practices, and a determination of the insurer's compliance levels. Fines will be ordered as determined by the Director in accordance with Rule 4-2.

(6) Insurers may be required to correct deficiencies in all claims covered by the audit period if the compliance level for any identified category is below 90%. Insurers may also be required to undergo training if indicated by audit results or for such other reasons as may be determined by the Director.

4-2 FINES

(A) An insurer's first audit conducted after January 1, 2006 measures and establishes the insurer's levels of compliance with applicable statutes and rules in identified categories. A compliance level below 90% in any compliance category is considered unsatisfactory. A compliance level below 90% in a compliance category listed in subparagraphs 1 through 7 in paragraph (B) of Rule 4-1, on consecutive compliance audits is considered repeated non-compliance. Repeated non-compliance in any category set out in Rule 4-1(B)(1) through (7) shall result in the insurer being ordered to pay a fine.

(B) In order for an insurer's unsatisfactory performance to result in fines for failure to meet the 90% compliance standard in any category set out in Rule 4-1(B)(1) through (7), its compliance level in that category must be below 90% on at least two consecutive audits.

(C) Each category for which a fine may be imposed has a fine schedule. The amount of any fine will be determined in accordance with the findings in the Final Audit Report and in accordance with this Rule 4-2. Fines for repeated violations in any category set out in Rule 4-1(B)(1) through (7) are based on the compliance level for that category and as set out in this Rule 4-2.

(D) The dollar amount of a fine is arrived at by first locating the insurer's compliance level on the appropriate schedule found in paragraph (E) of this Rule 4-2. The number of identified deficiencies in the relevant category is multiplied by the "per deficiency" dollar amount for the appropriately numbered finable occurrence indicated in the schedule to arrive at a fine amount for that category.

(E) The fine schedule for each finable compliance category is as follows:

(1) For the categories listed in Rule 4-1(B) subparagraphs 1,5,7:

	FINES PER AUDIT DEFICIENCY PER COMPLIANCE CATEGORY			
COMPLIANCE LEVEL	1ST FINABLE OCCURRENCE	2ND FINABLE OCCURRENCE	3RD AND LATER FINABLE OCCURRENCE	
80-89%	$30	$60	$90	
70-79%	60	90	120	
60-69%	90	120	150	
<60%	120	150	180	

(2) For the categories listed in Rule 4-1(B) subparagraphs 2,3,4,6:

	FINES PER AUDIT DEFICIENCY PER COMPLIANCE CATEGORY		
COMPLIANCE LEVEL	1ST FINABLE OCCURRENCE	2ND FINABLE OCCURRENCE	3RD AND LATER FINABLE OCCURRENCE
80-89%	$50	$100	$200
70-79%	100	200	400
60-69%	200	400	600
<60%	400	600	1000