Colorado Department of Labor and Employment
Division of Workers' Compensation

Claims Compliance Audit Guide

Division of Workers' Compensation
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March 6, 2008

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Definitions

Act—Colorado Workers' Compensation Act, Articles 40-47 of Title 8 of the Colorado Revised Statues (C.R.S.).

Audit inquiries – questions in identified categories considered by the auditor in connection with a compliance audit the answers to which are used to determine an insurer's compliance with the Act and WCRP in such categories.

Claim adjusting agent – a third-party claim administrator (TPA) or other claims adjusting entity that provides claim adjusting services to an insurance carrier or self-insured employer.

Compliance audit – a formal review, evaluation and assessment by division authorized personnel of an insurer's compliance with one or more duties under the act and rules.

Comment category – the classification of a group of identified duties under the Act and/or rules in which an insurer's claim handling performance is measured but where no fines are imposed for the insurer's failure to meet the compliance standard.

Compliance category – the classification of a group of identified duties under the act and/or rules in which an insurer's claim handling performance is measured and in which fines may be imposed for the insurer's *repeated* failure to meet the compliance standard.

Compliance level – the ratio of audit inquiries found to be in compliance with the Act and /or Rules when compared to the total number of applicable audit inquiries reviewed in that category.

Compliance standard – the rate of compliance, established by rule, that an insurer must meet in a given audit category in order for performance to be regarded as satisfactory. Failure to attain this standard in any Compliance Category on two or more consecutive audits will result in the imposition of fines.

Deficiency (also, 'error' or 'violation') –an act or omission considered by the division to be a failure to comply with statute, rule or order, regardless of whether the insurer acted in good faith or whether the insurer knew the action or omission was not in compliance.

Director—the Director of the Colorado Division of Workers' Compensation.

Division—the Division of Workers' Compensation within the Department of Labor and Employment for the State of Colorado.

Filed or Reported—date mailed or delivered unless otherwise specified.

Insurer—workers' compensation insurance carrier, self-insured employer, insurance pool, third-party administrator (TPA) and other claims administration entities with the

understanding that the ultimate responsibility and regulatory accountability for compliance with the Act and Rules rests with the insurance carrier or self-insured employer itself.

Indemnity claim—any claim that is required to be filed with the Division, i.e. lost time of more than three shifts or calendar days, permanent impairment or fatality.

Notice or notify— to provide actual or to have constructive knowledge of a fact.

Order—any decision, finding and award, direction, rule, regulation, or other determination arrived at by the director or an administrative law judge.

Repeated – to perform or to fail to perform an act more than once

Rules and WCRP—Colorado Workers' Compensation Rules of Procedure (7 CCR 1101-3) including Self-Insurance (7 CCR 1101-4) and Premium Cost Containment Rules (7 CCR 1101-6)

Overview

The responsibility and regulatory accountability for compliance with the Workers' Compensation Act ("Act") and Rules of Procedure ("WCRP") 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 Division. The term "insurer", when used in this *Guide,* includes an insurance carrier/self-insured employer's claim adjusting agent or third-party administrator (TPA) except that the ultimate responsibility and regulatory accountability for compliance with the Act and Rules rests with the insurance carrier/self-insured employer itself.

The purpose of this *Claims Compliance Audit Guide* is to provide information to those responsible for adjusting claims to assist them in understanding the Division's audit responsibilities and methods and to inform them about adjusting requirements needed to achieve and maintain acceptable audit compliance levels. This *Guide* lists the regulatory criteria governing compliance, outlines the audit inquiries used by Division personnel to evaluate compliance, and explains how fines may result when the compliance levels are unsatisfactory.

The Division's Carrier Practices Unit conducts compliance audits. The audit is an autonomous process. Division auditors analyze claim practices, assess compliance, report findings, and, when appropriate, direct corrective action and make recommendations for improving performance. Fines will be imposed on an insurer in those Compliance Categories where compliance levels are unsatisfactory on two or more consecutive compliance audits. Until the compliance audit is completed, all communication regarding audit issues must be directed to the auditor.

Authority of Director

C.R.S. Sections 8-47-101(2) and 8-47-102; **C.R.S. Section 8-43-218**

The Director and Division shall enforce and administer the provisions of the Act.

C.R.S. Section 8-43-304; Rule 4

Section 8-43-304(1.5) mandates fines for insurers who knowingly or repeatedly violate the Act. Rule 4 (WCRP) sets the standard for compliance.

C.R.S. Section 8-44-106; Self Insurance Rule Part 5(A) (7 CCR 1101-4),

Insurer license revocation and suspension is possible for intentionally, knowingly, or willfully violating any provisions of the Act and the Executive Director may consider revocation of a self-insurer's permit if the self-insured employer is unable to demonstrate acceptable claims administration.

Compliance Audits

Measurement of compliance is based on data from the Division's records and on the insurer's files and records. The objective of the auditor during a compliance audit is to measure insurer compliance with the Act and Rules in those categories determined by the Director and identified in Rule 4 as important to proper claim adjusting and to report the insurer's compliance levels in those categories.

Selection of Insurers for Audit

An insurer may be selected for audit based on

- number of indemnity claims filed with the Division
- rotation
- past or current performance
- complaints
- random designation

Audit Scope

Claims may be reviewed for compliance with the Act and Rules on any or all of the following matters:

- timely reporting by insurers of claims required to be filed with the Division to the Division
- timely statement of positions on liability (admission or denial)
- accurate calculation and admission of the average weekly wage based on acceptable wage verification
- accurate calculation and admission of benefit rates
- timely and accurate compensation payments
- timely medical benefit payment or denial of payment
- accurate calculation and admission of temporary disability benefits, consistent with supporting documentation including recovery of the "waiting period" when applicable
- timely and properly supported termination of temporary disability benefits
- timely admissions reinstating temporary disability benefits
- accurate calculation and timely admissions of offsets
- compliance with notices of liens and accurate calculation of benefit distribution
- accurate calculation and admission of permanent impairment benefits, consistent with supporting documentation
- accurate, complete, and timely final admissions with all issues resolved
- timely exchange of medical reports
- accurate reporting of the employer name and FEIN, insurer name and FEIN block number, adjuster code, and use of current forms; toll-free telephone number, certificate date of mailing, claim representatives name.

Audit Sample

The insurer's loss runs and Division records are used to select a sample of claims to audit. For insurers with 40 or fewer lost-time claims during an audit period or who have adjusted few claims since implementing suggested corrective procedures, all claims during the period may be audited.

The sample is normally taken from claims with dates of injury occurring within the 12 months preceding the date of the audit. Where a follow-up audit is needed to assess effectiveness of corrective procedures or where significant insurer changes have occurred within the 12 months preceding the date of the audit, the sample may include claims with dates of injury after the date that corrective procedures were implemented or after the changes occurred.

Audit Process

The Division will provide a notice of the compliance audit to the insurer not less than 15 calendar days prior to the auditor's arrival on-site unless the Division determines that circumstances warrant otherwise. The notice will describe the audit process generally and a copy of this *Claims Compliance Audit Guide* will be enclosed with the notice. The notice will identify the claims to be audited, confirm the dates the auditor will be on site, and identify the information required to be provided to the auditor prior to and/or at the time of the auditor's arrival on site. Such information may include but is not limited to:

- answers to questions regarding the insurer operations
- the dates the employer and insurer were notified of a condition requiring filing
- insurer's original claim files and access to all electronic claim data
- wage verification for claims with an admitted average weekly wage
- wage records for claims with admitted TPD, for the period of TPD
- a printout of all compensation payments on each listed claim
- dates of receipt of all or a designated set of medical bills
- dates of payment of medical bills or copies of notices indicating payment was contested including the reason for the contest
- a list of claims for which actual checks or other verifiable payment documentation must be made available to the auditor to confirm the accuracy of information on payment printouts
- 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

At an initial interview, the auditor will review the audit process with the insurer and answer preliminary questions regarding the process. The auditor will review the insurer's operations to obtain an understanding of the information in the insurer's claim adjusting system.

Compliance Categories vs. Comment Categories

Audit categories are divided into two types: Compliance Categories and Comment Categories.

Compliance Categories are those seven (7) areas in which the Director has determined that compliance with the act and rules is of the highest importance and in which failure to maintain a satisfactory compliance level (90%) on two or more consecutive audits will result in fines being assessed.

Comment Categories are those three (3) areas in which the Director has determined that compliance is important but where varying circumstances require latitude in application of regulatory criteria and where insurer performance does not result in fines if compliance levels within those categories are below the satisfactory compliance level (90%).

The Compliance Categories

Auditors measure and report insurer compliance levels in the following seven (7) **Compliance Categories**. Insurers who fail to achieve a satisfactory compliance level (90%) in any Compliance Category on two or more consecutive audits will be fined for the deficiencies in those categories in accordance with Rule 4.

1. Reporting of Claims

Regulatory Criteria

§ 8-43-101; § 8-43-103(1); Rule 5-2(A) and (B); Rule 5-1

As of July 1, 2006, all First Reports of Injury and Notices of Contest must be transmitted to the Division electronically, either via electronic data interchange ("EDI") or via the Division's internet filing process. Claims must be established with the Division with a workers' compensation number assigned before any Position on Liability (admission or denial) will be accepted.

Information must be submitted to the Division in the format prescribed by the Division and must be complete and accurate. Non-compliant submissions may not be accepted and therefore may affect the timeliness of those submissions. The employer and insurer must be identified accurately with the correct name and federal employer's identification number ("FEIN").

Inquiries Used to Determine Compliance

- Within the time prescribed, was the First Report of Injury (FROI) properly transmitted to and accepted by the Division prior to the Division's receipt of the insurer's Initial Position on Liability

2. Initial Positions on Liability

Regulatory Criteria

§ 8-43-203; Rule 5-2(C); Rule 5-2(D)

Inquiries Used to Determine Compliance

- Did the insurer timely admit or deny liability based on the date the First Report was filed
- If notice of a claim was based on a Worker's Claim or Dependents' Claim, did the insurer timely admit or deny liability based on the date the Division mailed the claim form to the insurer

3. Timeliness of Compensation Payments

Regulatory Criteria

Regarding Initial Payments

§ 8-42-105(2)(a); § 8-43-203(2)(b); Rule 5-6(A);Rule 5-6(B); Rule 5-6(C)

Regarding Subsequent Payments

§ 8-42-105(2)(a); Rule 5-6(A); Rule 5-6(B); Rule 5-6 (C)

Inquiries Used to Determine Compliance

- Was the initial payment made at the time of the admission
- Was the initial payment made so that the claimant would receive the check within five calendar days after the date of the admission
- Was the initial payment made within the time required to admit liability
- Did payment include all amounts due at the time of payment
- Were subsequent payments made on a schedule of at least once every two weeks from the date benefits first became due
- Did payments coincide with dates of admissions for additional benefit periods admitted

4. Accuracy of Compensation Benefits

Regulatory Criteria

Regarding Benefits Admitted, Calculated, and Paid Accurately

§ 8-42-103(1)(b); § 8-42-105(1) and § 8-42-106(1); § 8-42-107; § 8-42-124(2)(a); Rule 1-8; Rule 5, Rule 6 and § 8-43-301(13)

Inquiries Used to Determine Compliance

- Were benefit totals calculated accurately
- Were admitted benefits modified properly
- Were benefits calculated according to statute
- Were benefit periods due reflected accurately
- Were admissions timely upon reinstatement of benefits
- Was the total amount due paid accurately
- Was the total amount due admitted accurately
- Did the total paid equal the total admitted
- Was the issue of overpayment properly addressed
- Was any lump sum discount applied accurately and taken properly
- Did the admitted impairment coincide with the rating

5. Medical Benefit Payments

Regulatory Criteria: § 8-43-401(2)(a); Rule 16-11.

Inquiries Used to Determine Compliance

- Was payment made within 30 days of receipt of the bill
- Was the bill properly contested within 30 days of receipt
- Did the bill contain the insurer's date of receipt

6. Termination of Temporary Disability Benefits

Regulatory Criteria

§ 8-42-105(3); § 8-42-106(2); Rule 6; Rule 5-5(C).

Inquiries Used to Determine Compliance

- If benefits were terminated, was an admission filed or Order entered
- If benefits were terminated by admission, did proper supporting documentation accompany the admission
- Did supporting documentation comply with Rule 6
- Was the date of termination consistent with supporting documentation
- Was an admission with supporting documentation filed or Order received within the time the next payment was due

7. Final Admissions

Regulatory Criteria

§ 8-43-203(2)(b)(II); Rule 5-5(E), (F) & (H); § 8-42-107(2)-(7); § 8-42-107(8); Rule 5-5(A); Rule 1-4; Rule 7-1.

Inquiries Used to Determine Compliance

- Was the Final Admission (FA) filed timely and did it contain a proper Certificate of Mailing and proper notices to claimant
- Was the medical report upon which the FA was based filed with the FA and was the medical report specifically referenced in the FA
- Were permanent impairment benefits admitted pursuant to statute and consistent with the final medical report from a Level II physician or consistent with an indication of 'no impairment' by ATP
- Was there a statement of the insurer's position on medical benefits after MMI
- Was an FA based on the provisions of Rule 7 filed in accordance with the requirements of Rule 7 and comply with Rule 7

The Comment Categories

Auditors also measure and report insurer compliance levels in the following three (3) **Comment Categories**. However, unlike **Compliance Categories**, an insurer's failure to meet a 90% compliance level in **Comment Categories** will not result in fines being imposed for the failure to achieve that compliance level.

1. Average Weekly Wage

Regulatory Criteria: § 8-40-201(19); § 8-42-102

Inquiries Used to Determine Comment

- Did the insurer examine and rely on actual wage records or other acceptable verification
- Did the insurer verify the time period covered by the wage records
- Was the time period calculated accurately
- Was the rate of remuneration at the time of the injury considered
- Were overtime wages included
- Were wages from other employment considered
- Was other relevant information considered in establishing the AWW
- Was the AWW reflected accurately on admissions

2. Waiting Period

Regulatory Criteria: § 8-42-103(1)(a) & (b)

Inquiries Used to Determine Comment

- Was the waiting period recoverable and, if so, admitted and paid correctly

3. Document Exchange

Regulatory Criteria: Rule 5-4(A) (5)

Inquiries Used to Determine Comment

- Were medical reports that were not required to be filed with the Division, forwarded to all parties
- Were medical reports that were required to be exchanged with the parties forwarded within 15 working days of receipt

Preliminary Audit Findings and Final Audit Report Process

Exit Conference

Following collection and review of data from audited files and loss runs, the auditor may meet with the insurer representative at or near the time of completion of the on-site phase of the compliance audit. Anticipated preliminary findings may be discussed at that time and immediate corrections may be required.

Preliminary Audit Findings

Audit data are collated, analyzed and evaluated by the auditor and at least one other Division reviewer. Preliminary audit findings, including identification of deficiencies, are prepared. Individual claims may be identified for immediate correction or for follow up. These preliminary findings including compliance levels, and, where applicable, a list of claims to be corrected or upon which additional information is required, are then sent to the insurer as preliminary audit findings.

Agreement on Preliminary Audit Findings

By Rule, the insurer has 30 calendar days within which to agree in writing to the preliminary audit findings or, alternatively, to state with particularity and in writing to the auditor, its reasons for all disagreement with the preliminary findings. The insurer is required to substantiate all disagreements in writing by providing the authority in fact and/or in law upon which it relies in support of its disagreements. Failure to specify and support disagreements with the preliminary findings during this time will result in a waiver of all such disagreements and will constitute the insurer's acceptance of and agreement with the auditor's findings. Accordingly, the insurer should try to resolve all differences over the preliminary findings with the auditor and reach written agreement with the auditor on the findings within this 30 day period.

If the insurer submits a proper and timely written disagreement with the auditor's preliminary audit findings, then the insurer, the auditor, and the auditor's manager will have 20 calendar days from the date the auditor receives the insurer's written disagreement(s) within which to resolve those disagreements and to agree to the

preliminary findings. If the auditor, the auditor's manager, and the insurer are unable to agree on the preliminary findings within the 20 day period afforded, 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. 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.

Final Audit Report

When the insurer has agreed to the audit findings or does not submit written disagreement in a timely manner, or, as is otherwise provided by Rule, the Final Audit Report will be issued. 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. Any fines arising from an audit will be determined by statute and rule.

Insurers may be required to correct deficiencies in all claims covered by the audit period if compliance levels are below 90% or for such other reasons as may be required by the Director. The insurer is required to demonstrate to the satisfaction of the Director that all deficiencies identified for correction have been corrected.

Frequency

Frequency of audits will generally depend on the insurer's reaching and maintaining satisfactory compliance levels. Insurers can expect increased audit frequency if compliance levels continue to be unsatisfactory.

Training

Insurers may be required to undergo training by Division personnel if indicated by audit results or as may be otherwise determined by the Director. The auditor may recommend adjuster training. The insurer may also request training. Training can address those areas identified by the audit for improvement and/or all compliance areas covered by the audit as well as other adjusting questions.

Fines

An insurer's first audit conducted after January 1, 2006 establishes the insurer's levels of compliance with statutes and rules in identified categories although no fines will be imposed on this audit for an insurer's failure to achieve satisfactory compliance levels. A compliance level below 90% is considered to be unsatisfactory. However, insurers below satisfactory compliance are expected to improve compliance before the next compliance audit. A compliance level below 90% in a Compliance Category on consecutive compliance audits is considered repeated non-compliance. Repeated non-compliance in Compliance Categories will result in the insurer being ordered to pay fines for unsatisfactory compliance in those categories. For an insurer's unsatisfactory performance to result in fines for failure to meet the 90% compliance standard in any Compliance Category, its

compliance level in that category must be below 90% on at least two consecutive audits.

Compliance Standard

Compliance levels below 90% are unsatisfactory and, if they occur in Compliance Categories on two or more consecutive audits, will result in fines

Compliance Emphasis

Auditors emphasize the timely and accurate delivery of compensation benefits to injured workers. Although for audit purposes a 90% compliance level is considered satisfactory, the expectation is that all compensation payments will be paid accurately and on time. Special attention is also given to unilateral terminations of temporary disability benefits and additional sanctions may be imposed where benefits are delayed thereby.

Calculation of Fines and Fine Schedules

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

The dollar amount of a fine is arrived at by first locating the insurer's compliance level on the appropriate schedule (see below) found in paragraph (E) of WCRP 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 unsatisfactory occurrence listed in the schedule to arrive at a fine amount for that category.

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

1. For the categories listed in WCRP 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

EXAMPLE

The following example illustrates how fines under Rule 4 would (or would not) apply.

The overall compliance levels of the Colorado workers' compensation claims of insurer LARGE, Inc., that resulted from the first compliance audit conducted in March, 2006 ("baseline") by the Colorado Division of Workers' Compensation's Carrier Practice Unit ("CPU") were as follows:

1. Reporting of claims 70%
2. Initial positions on liability 89%
3. Timeliness of compensation payments 85%
4. Accuracy of compensation benefits 90%
5. Medical benefit payments 91%
6. Termination of temporary benefits 75%
7. Final Admissions 90%
8. Average Weekly Wage N/A
9. Waiting period N/A
10. Document exchange N/A

In July, 2007, the Division advised the insurer, LARGE, Inc., that the CPU intended to conduct the second compliance audit of the insurer's Colorado workers' compensation claims again to include those Colorado claims underwritten by the insurer's companies that met the Division's criteria for audit. LARGE, Inc. was required to and did advise the Division of the name, address and contact person for the companies underwriting these claims as well as the names and locations of those third-party administrators that adjusted them. Applying the audit criteria, the Division determined that two third-party administrators ("TPAs") adjusted these claims and met the Division's criteria, FIRSTPA, Inc., and SECND, Inc.

The Division notified LARGE, Inc., FIRSTPA, Inc. and SECND, Inc. that compliance audits would be conducted at FIRSTPA, Inc's Colorado Springs, Colorado location and at SECND, Inc.'s Fort Collins, Colorado location.

The audit at FIRSTPA, Inc. in Colorado Springs, Colorado reviewed 38 of the insurer's indemnity claims as well as selected denied claims established with the Division with dates of injury from June, 2006 through June, 2007 as adjusted by FIRSTPA, Inc.

The audit of these 38 claims as adjusted by FIRSTPA, Inc. resulted in the following findings in the categories noted:

1. Reporting of Claims Required to be Filed with the Division:

   Of the 38 claims in which it could be determined when the employer had notice of a condition required to be filed with the Division, 30 of the First Reports of Injury were filed timely. **The compliance level was 79%.**

2. Initial Positions on Liability

   Of the 38 claims in which an Employer's First Report of Injury, a Worker's Claim for Compensation or a Dependants' Notice of Claim was filed with the Division requiring a position statement, 33 of the position statements were timely. **The compliance level was 87%**.

3. Timeliness of Compensation Payments

   The criteria, derived from audit inquiries, considered for determining compliance in the *Timeliness of Compensation Payments* category were "timeliness" and "payment made through the due date". In the 38 claims audited, there were a total of 205 indemnity payments reviewed, each of which involved the two (2) considerations of "timeliness" and "payment made through the due date" (205 x 2 = 410). Of these 410 considerations, 330 were compliant. **The compliance level was 80%.**

4. Accuracy of Compensation Benefits

   The criteria, derived from audit inquiries, considered for determining compliance in the *Accuracy of Compensation Benefits* category were whether or not disability benefits were "calculated" and "paid" and "admitted accurately". Of 38 claims audited, 36 claims involved payment of disability benefits, each of which involved the three (3) considerations for accuracy of "calculated", "paid" and "admitted" benefits (36 x 3 = 108). Of these 108 considerations, 102 were compliant. **The compliance level was 94%.**

5. Medical Benefit Payments

   Of 153 medical bill payments reviewed in the 38 claims, 146 payments were paid timely. **The compliance level was 95%.**

6. Termination of Temporary Disability Benefits

The criteria, derived from audit inquiries, considered for determining compliance in the category of *Termination of Temporary Disability Benefits* were "timeliness" and "support provided pursuant to Rule". In 38 claims, there were 47 circumstances where temporary disability benefits were terminated, each of which involved the two (2) considerations of "timeliness" and "support provided pursuant to Rule" (47 x 2 = 94). Of these 94 considerations, 72 were either properly supported and/or filed timely in accordance with Rules 5-5(C) and 6. **The compliance level was 77%**.

7. Final Admissions

   The criteria, derived from audit inquiries, considered for determining compliance in the category of *Final Admissions* were:

   1. Timeliness of the FA with a proper Certificate of Mailing and proper notices to claimant
   2. Final medical report referenced in FA and attached to FA
   3. Permanent benefits admitted pursuant to statute and consistent with final medical report by Level II physician or containing indication of 'no impairment' by ATP
   4. Statement of position on medical benefits after MMI
   5. Compliance with Rule 7 where FA based on Rule 7

   In 38 claims, there were 28 claims where Final Admissions were filed, each of which involved four (4) of the five criteria, i.e., (1) timeliness of the FA with proper Certificate of Mailing and proper notices to claimant and (2) final medical report referenced in FA and attached to FA and (3) permanent benefits admitted pursuant to statute and consistent with final medical report by Level II physician or containing indication of 'no impairment' by ATP and (4) statement on medical benefits after MMI (28 x 4 = 112). Of these 112 considerations, 104 were compliant. **The compliance level was 93%.**

Because fines for an insurer's failure to meet the 90% compliance standard are not imposed in the categories of (8) Average Weekly Wage, (9) Waiting period or (10) Document exchange, those categories are not included in this Example).

The audit of the insurer's claims at SECND, Inc. in Fort Collins, Colorado, reviewed 47 of the insurer's indemnity claims as well as selected denied claims established with the Division with dates of injury from June, 2006 through June, 2007 as adjusted by SECND, Inc.

1. Reporting of Claims Required to be Filed with the Division:

   In 40 claims where it could be determined when the employer had notice of a condition required to be filed with the Division, 32 of the First Reports of Injury were filed timely. **The compliance level was 80%.**

2. Initial Positions on Liability

   In 40 claims in which an Employer's First Report of Injury, a Worker's Claim for Compensation or a Dependants' Notice of Claim was with the Division requiring a position statement, 31 position statements were timely. **The compliance level was 78%.**

3. Timeliness of Compensation Payments

   The criteria, derived from audit inquiries, considered for determining compliance in the *Timeliness of Compensation Payments* category were "timeliness" and "payment made through the due date". In the 47 claims audited, there were a total of 189 indemnity payments reviewed, each of which involved the two (2) considerations of "timeliness" and "payment made through the due date" (189 x 2 = 378). Of these 378 considerations, 272 were compliant, a **compliance level of 72%.**

4. Accuracy of Compensation Benefits

   The criteria, derived from audit inquiries, considered for determining compliance in the *Accuracy of Compensation Benefits* category were whether or not disability benefits were "calculated" and "paid" and "admitted accurately". Of 47 claims audited, 37 claims involved payment of disability benefits, each of which involved the three (3) considerations for accuracy of "calculated", "paid" and "admitted" benefits (37 x 3 = 111). Of these 111 considerations, 90 were compliant. **The compliance level was 81%.**

5. Medical Benefit Payments

   Of 125 medical bill payments reviewed, 123 were paid timely. **The compliance level was 98 %.**

6. Termination of Temporary Disability Benefits

   The criteria, derived from audit inquiries, considered for determining compliance in the category of *Termination of Temporary Disability Benefits* were "timeliness" and "support provided pursuant to Rule". In 47 claims, there were 34 circumstances where temporary disability benefits were terminated, each of which involved the two (2) considerations of "timeliness" and "support provided pursuant to Rule" (34 x 2 = 68). Of these 68 considerations, 42 were either properly supported and/or filed timely in accordance with Rules 5-5(C) and 6. **The compliance level was 62%.**

7. Final Admissions

   The criteria, derived from audit inquiries, considered for determining compliance in the category of *Final Admissions* were:

   1. Timeliness of the FA with a proper Certificate of Mailing and proper notices to claimant

2. Final medical report referenced in FA and attached to FA
3. Permanent benefits admitted pursuant to statute and consistent with final medical report by Level II physician or containing indication of 'no impairment' by ATP
4. Statement of position on medical benefits after MMI
5. Compliance with Rule 7 where FA based on Rule 7

In 47 claims, there were 24 claims where Final Admissions were filed, each of which involved four (4) of the five criteria, i.e., (1) timeliness of the FA with proper Certificate of Mailing and proper notices to claimant and (2) final medical report referenced in FA and attached to FA and (3) permanent benefits admitted pursuant to statute and consistent with final medical report by Level II physician or containing indication of 'no impairment' by ATP and (4) statement on medical benefits after MMI (24 x 4 = 96). Of these 96 considerations, 80 were compliant. **The compliance level was 83%.**

SUMMARY OF AUDIT FINDINGS
FOR LARGE, INC.

Compliance Categories	**LARGE'S 2006 baseline**	**LARGE'S 2007 audit**	**Fines?**
1. Reporting of claims	70%	79%	Y
2. Initial positions on liability	89%	82%	Y
3. Timeliness of comp. payments	85%	76%	Y
4. Accuracy of comp. benefits	90%	88%	N
5. Medical benefit payments	91%	97%	N
6. Termination of temporary benefits	75%	70%	Y
7. Final Admissions	90%	88%	N
Comment Categories (not included in this example)			
8. Average Weekly Wage			N
9. Waiting period			N
10. Document exchange			N

QUESTION #1: Will LARGE'S July 2007 audit result in fines?

Answer: Yes.

This is LARGE, Inc.'s second (consecutive) audit after January, 2006. LARGE, Inc. failed to meet the 90% compliance standard in certain categories in its 2006 audit. LARGE, Inc. has again failed to meet the 90% compliance standard in the present audit (July 2007) of its claims handled by FIRSTPA, Inc. and SECND, Inc. in the following Compliance Categories: *Reporting of Claims*, *Initial Positions on Liability, Timeliness of Compensation Payments and Termination of Temporary Disability Benefits*.

Therefore, fines will be assessed against LARGE, Inc., for deficiencies in these categories.

Although LARGE, Inc. also did not meet the 90% compliance standard in the categories of *Accuracy of Compensation Benefits* and *Final Admissions*, LARGE, Inc.'s compliance level in those categories in the 2006 audit was satisfactory i.e., 90% or greater. Therefore, by rule, no fine will be imposed (WCRP 4-2(A)) since noncompliance in these categories did not occur in *consecutive* audits.

QUESTION #2: How will LARGE, Inc.'s fines be determined?

Answer:

LARGE, Inc.'s fines are determined in accordance with WCRP 4-2(A) through (E). Because LARGE Inc.'s compliance level did not meet the 90% compliance standard established by Rule 4-1(C) in the categories of *Reporting of Claims, Initial Positions on Liability, Timeliness of Compensation Payments* and *Termination of Temporary Disability Benefits*, fines will be imposed for deficiencies in those categories.

For the category *Reporting of Claims*, LARGE Inc.'s compliance level was 79% with sixteen (16) total deficiencies identified (8 deficiencies by FIRSTPA, Inc. *and* 8 deficiencies by SECND, Inc. = 16 deficiencies). LARGE, Inc. has had no prior "finable occurrence" in this category. The "per deficiency" dollar amount per Rule 4-2 (E) (1) is $60. Accordingly, the fine for a 79% compliance level in this category is $960 ($60/deficiency x 16 deficiencies).

For the category *Initial Positions on Liability*, LARGE, Inc.'s compliance level was 82% with fourteen (14) total deficiencies identified (5 deficiencies by FIRSTPA, Inc. *and* 9 deficiencies by SECND, Inc. = 14 deficiencies). LARGE, Inc. has had no prior "finable occurrence" in this category. The "per deficiency" dollar amount per Rule 4-2(E)(2) is $50. Accordingly, the fine for an 82% compliance level in this category is $700 ($50/deficiency x 14 deficiencies).

For the category *Timeliness of Compensation Payments*, LARGE, Inc.'s compliance level is 76% with one hundred eighty-six (186) total deficiencies identified (80 deficiencies by FIRSTPA, Inc. *and* 106 deficiencies by SECND, Inc. = 186 deficiencies). LARGE, Inc. has had no prior "finable occurrence" in this category. The "per deficiency" dollar amount per Rule 4-2(E)(2) is $100. Accordingly, the fine for a 76% compliance level in this category is $18,600 ($100/deficiency x 186 deficiencies).

For the category *Termination of Temporary Disability Benefits*, LARGE, Inc.'s compliance level was 70% with forty-eight (48) total deficiencies identified (22 deficiencies by FIRSTPA, Inc. *and* 26 deficiencies by SECND, Inc. = 48 deficiencies). LARGE, Inc. has had no prior "finable occurrence" in this category. The "per deficiency" dollar amount per Rule 4-2(E) (2) is $100. Accordingly, the fine for a 70% compliance level in this category is $4,800 ($100/deficiency x 48 deficiencies).

The insurer's total fine resulting from the 2007 audit of its Colorado WC claims as adjusted by FIRSTPA, Inc. *and* SECND, Inc. is $25,060 ($960 + $700 + $18,600 + $4,800).

QUESTION #3: If the next audit of the insurer's claims is completed in 2009, irrespective of who has or is adjusting its claims but LARGE, Inc.'s compliance level is again below 90% in a compliance category for which a fine was imposed as the result of the 2007 audit, will the "per deficiency" dollar amount increase to a "**2nd finable occurrence"** (Rule 4-2(E)(1) and (2))?

Answer: Yes.

The responsibility and regulatory accountability for compliance with the Act and Rules rests with the insurance carrier/self-insured employer.

QUESTION #4: Will LARGE, Inc. be fined for failure to meet the compliance standard (90%) in a compliance category in the next audit (2009) where the insurer's compliance level was below 90% in that category in its 2006 audit but at or above 90% in that category in its next, consecutive audit (2007) irrespective of who has or is adjusting its claims?

Answer: No.

Per Rule 4-2(B), in order for LARGE, Inc.'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), LARGE, Inc.'s compliance level in that category must be below 90% on at least two consecutive audits irrespective of who has or is adjusting its claims.